The Dissertation Committee for Benjamin Nieto-Andrade certifies that this is the approved version of the following dissertation:

Risk Taking Behavior in HIV-Discordant Male Couples in the Metropolitan Area of Mexico City

Committee:

Debra J. Umberson, Supervisor

Gloria Gonzalez-Lopez

Yolanda Padilla

Joseph. E. Potter

Thomas W. Pullum

Risk Taking Behavior in HIV-Discordant Male Couples in the Metropolitan Area of Mexico City

by

Benjamin Nieto-Andrade, B.A.; M.A.

Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas at Austin

May, 2007

Dedication

To the people living with HIV and their partners who shared parts of their lives with me.

To Vania Salles, who always supported my professional career.

To the memory of my mother, Raquel Andrade, who instilled in me the desire to learn a little bit more everyday and to be unafraid of hard work.

Acknowledgements

The present dissertation was possible due to the support of many people and institutions. In the first place, I want to acknowledge the participation of HIV-positive men and their partners in the interviews. Their trust in my project and their willingness to share with me important aspects of their lives were both an invaluable source of information. I am totally indebted to them and I hope to make a fair tribute to their admirable lives. Although some respondents gave me permission to use their real names, I decided to keep their confidentiality in all cases. As it will be seen in the body of this dissertation, I use pseudonyms to refer to them. In spite of not spelling out their real names, my greatest accolades and appreciation goes to all of them. Without their voices this dissertation would not have been possible.

I am also strongly indebted to the men and women in Mexico who enthusiastically received my project and facilitated the process of contacting interviewees. I am especially thankful to Eduardo Catalan who connected me to physicians, patients and organizations concerned with HIV/AIDS. He also provided office space to conduct the interviews in an environment of confidentiality and privacy at Comunidad Unida en Respuesta al SIDA (CURAS, A.C). Physicians, directors of clinics, leaders of governmental organizations, social workers, and health personnel in general made my recruiting process easier. For that reason I am thankful to: Lourdes Chi, Juan Carlos Fernandez, Rocio Lazzo, Angelica Hernandez, Alberto Carrillo, Mauricio Ramos, Carmen Soler, Manuel Feregrino, Adan Flores, Jorge Rivera, Ernestina Rojas, Luis Alberto Silva, Blanca Garces, Francisco Rodriguez, Francisco Hernandez, Paula Gonzalez, Isolina Cardenas, Carlos Garcia de Leon, Ninel Diaz, Jose Luis Lopez, Rodolfo Perez Cobian, Juan Gabriel Duran, Sandra Treviño and David Vargas. Thanks to all of them for their patience with my constant phone calls, visits to their organizations, and sensitivity about the continued progress of my investigation. Thanks also to Porfirio Hernandez for the bibliography with which he provided me.

The generous support of the Mellon Foundation, through the Population Research Center at the University of Texas at Austin, was also a key factor that made my field work possible. The efficiency at the Popular Research Center allowed me put off administrative work in the United States and to concentrate on my research fieldwork in Mexico. Without such help the dissertation experience would have been difficult. Special thanks to Mary de la Garza for her always friendly and quick assistance.

I also want to acknowledge the support of different institutions during my graduate studies at the University of Texas at Austin. A partial scholarship from CONACYT during 1999-2001 was the initial springboard that allowed me to start the graduate program at UT. It paid for part of my tuition and personal expenses and helped me to get other complementary fellowships. The Ford and Hewlett Foundations, for example, added to my personal income from 1999-2001 and from 1999-2002, respectively. Without such scholarships my enrollment at UT would have been simply unthinkable.

Vital to the centering of my dissertation topic around HIV/AIDS was my participation as a trainee at the AIDS International Training and Research Program at Emory University. During the summer of 2000 and fall of 2001 I received a Fogarty scholarship to attend classes on HIV/AIDS and public health. My experience at Emory University was fundamental to my professional development, and it was also personally meaningful. It allowed me both to learn different approaches to research on HIV/AIDS and to delve into methodological issues of public health. My stay at Emory University strengthened my convictions about studying HIV-AIDS as a way to improve the lives of those most affected by the disease. Jennifer Hirsch and Carlos del Rio from Emory University were important mentors. They provided initial comments about the feasibility of studying HIV-discordant couples in Mexico. Jennifer Hirsch additionally carefully read the initial stages of the project and provided me with insightful comments and a bibliography.

I would also like to express my gratitude to my adviser and readers for their guidance throughout this investigation. Debra Umberson gave me important comments and observations that allowed me to decide between different paths of

research. Her guidance was always wise and was offered within a framework of complete liberty. Gloria Gonzalez-Lopez and Yolanda Padilla both showed close interest in the course of the project and spent time reviewing my progress. Their detailed reading of the project and communication through emails were very helpful to polish the dissertation. There is no way I can repay the importance of the time they invested in my dissertation. I also appreciate the support Joseph Potter and Thomas Pullum offered to this dissertation, as well as the mentoring they provided throughout different stages of my graduate studies. They were the people to whom I turned when problems arose.

An important part of my experience in Austin is due to my friends and classmates. I owe them many good memories of life in the United States. They shared with me their knowledge about the University and the City of Austin, and they offered me an indispensable web of information: from trivial things about everyday life to how to deal with administrative procedures. For our time together in the movie theatres, our conversations about Mexican politics, our driving instructions, our thoughts about relationships, birthday dinners, night life in Austin, long hours in the swimming pool, simultaneous conversations in Spanglish and Portoñol, 'unforgettable' comps-study-sessions, trips to New Orleans and San Antonio, or just spending time together without any other concern in mind, thanks to Anita McClindon, Georgina Rojas, Sonia Frias, Sandra Valonguiero, Ricardo Mora, Maren Jimenez, Tania Vasquez, Susana Adamo, Patricio Solis, Thomas Preusser, Ernesto Amaral, Lorena Gonzalez, Ginger Gossman, Juan Piñon, Enrique Ibarra, Alberto Mackelligan, Almir de Oliveira, Diana de Oliveira, Lucia Osa-Melero, Cristina Martinez, Vladimir Trifonov, Xuhui Li and many other friends.

During my field work in Mexico in 2004-2005, old and new friends helped me to settle down and to make my stay a good experience. They listened to my difficulties and achievements with the project and the readjustment to "la otrora 'región más transparente del aire' " (the former most clear-aired region, Alfonso Reyes, 1956: 13). They gave face and character to the streets, plazas, cantinas and much more. I am thankful to Roberto Blanco, Martha Ramirez, Elizabeth Garcia, Martha Castro, Kent Katner, Samuel Rodriguez, Argentino Mendoza, Rocio Mondragon, Michelle Dion,

Jennifer Tovar, Rene Garcia, Otto Lens, Jose Luis Ramirez, Javier Toscano and Esteban Garza (even if you are not there anymore).

Thanks also to Erin Boade for editing help with the final English version of this dissertation. And last but not least, I want to express my gratitude to my family that has always supported me and been a part of me: my father, Lorenzo Nieto; my siblings Rafael, Margarita, Lorenzo, Lourdes, Jesus and Salome; and my countless nieces and nephews.

Risk Taking Behavior in HIV-Discordant Male Couples in the Metropolitan Area of Mexico City

Publication No._____

Benjamin Nieto-Andrade, Ph. D.
The University of Texas at Austin, 2007

Supervisor: Debra J. Umberson

This research explores the meanings of sexual activity and condom use in HIV-discordant male couples in Mexico City (couples in which only one partner is HIV-positive). For that purpose it draws on forty-four in-depth interviews with men in a current or past HIV-discordant relationship. The general motivation for this research is to explore the factors that, besides knowledge about HIV/AIDS, influence sexual behavior and unprotected sex. In populations at risk for HIV infection, information about prevention is not translated into consistent condom use (Geringer et al., 1990). Empirical studies show that people practice unsafe sex even after learning about the risk of certain sexual practices and the effectiveness of condoms to avoid any sexually transmitted disease (Davis, 2002). Doing research on the meanings that people give to sex and condoms in their everyday lives will also contribute to understanding the behavior that reduces or facilitates the transmission of HIV.

Along with previous studies, the present results indicate that for all respondents, sexual interaction is an emotional and meaningful event in the context of their current relationships. All respondents framed their sexual practices with their understanding of commitment and what they expect from a relationship. Results also indicate that an important number of respondents engage in practices of unprotected sex in spite of knowing their discordance regarding HIV. For them raw sex is a way to express their

commitment to the relationship, to express how much they are willing to give to each other. These men conceive of a relationship as abandoning oneself to another and sharing the same destiny. Conversely, another important number of men reported condom use on a frequent basis. These men referred to commitment as a way of maintaining each others' wellbeing: preventing primary and secondary infection. For them a relationship is about mutual responsibility of taking care of the couple's well being. The policy implication of these results is that health programs should enhance the idea of commitment as mutual care to reduce practices of risky sex. Conversely, health programs should eliminate the perception of commitment as mutual abandonment and sharing the same destiny.

Table of Contents

LIST OF TABLES **XVII**

CHAPTER 1: INTRODUCTION **1**

CHAPTER 2: THEORETICAL APPROACH **7**

2.1 Introduction....7

2.2 Symbolic Interaction Perspective....8

2.3 Social Construction of Reality....10

2.4 Social Organization of Sexuality....12

2.5 Socio Cultural Characteristics of Homosexuality in Mexico....14

a) The Idea of Love and Romance....14

b) Familism and Sexual Silence....16

c) Attitudes towards non-heterosexual behavior....18

CHAPTER 3: REVIEW OF EMPIRICAL LITERATURE **24**

3.1 Introduction....24

3.2 Sexual Practices in HIV-Discordant Male Couples....24

a) Frequency of Sexual Activity....24

b) Anal Intercourse and Condom Use....25

c) Oral Sex and Protection....27

d) Sexual Activity with Primary Partner versus Casual Sex....28

3.3 Meanings of Sex....29

a) As an Expression of Masculinity....31

b) As an Expression of Emotional Intimacy....33

3.4 The Meanings Attached to Lack of Condom Use....35

a) Unprotected Sex as a Marker of Stability....36

b) Unprotected Sex and the Re-establishment of an Undesired Imbalance....38

3.5 Conclusions of Literature Review 39

CHAPTER 4: DATA AND METHODS **43**

4.1 Selection Procedure 43

4.2 Recruitment and fieldwork 44

4.3 Data Collection 47

4.4 IRB Approval and Ethical Issues 48

4.5 Data Analysis 48

4.6 Generalizability of Results 49

4.7 Validity and Reliability 50

a) Veracity 50

b) Memory Problems 52

c) Reliability 53

CHAPTER 5: CHARACTERISTICS OF RESPONDENTS **54**

5.1 Introduction 54

5.2 Socio-demographic Characteristics 54

5.3 Sexual Identity of Respondents 61

5.4 Disclosing Sexual Preference 64

5.5 Disclosing HIV status to other people 66

a) Only my Partner and other HIV-Positive Men 66

b) Some members of my family 67

5.6 Conclusions 69

CHAPTER 6: BECOMING AWARE OF HIV-DISCORDANCE **71**

6.1 Introduction 71

6.2 HIV-Positive Men 71

a) Initial Diagnosis 71

a.1) HIV Test when Deeply Sick 72
a.2) HIV Test due to Small Health Problems 73
a.3) Testing For HIV as a Routine 74
b) How Did I Get Infected? 75
b.1) HIV as an Invention to Stop Homosexuality 75
b.2) Trust in Long Term Friendship 76
b.3) Perception of Condoms as Facilitating Promiscuity 77
b.4) Low self-esteem and Expectation of Romance 78
6.3 HIV-Negative Men 80
a) Initial Reaction before Revelation of Partner's HIV Status 80
b) Reasons for Continuing in the Relationship 81
c) Emotional Stability Provided by a Partner 82
d) Partner's Integrity and Honesty 84
e) Association between Risk of Infection and Pleasure 85
6.4 Conclusions 86
CHAPTER 7: EFFECT OF HIV DISCORDANCE ON SEXUAL LIFE 88
7.1 Introduction 88
7.2 Impact of HIV on the Frequency of Sex 88
a) Initial Period of Adjustment 88
b) Resuming Sexual Activity: Couples Aware of Discordance after Long Period in Relationship 93
7.3 Impact on the Type of Practices 96
a) Knowing Discordance at the Beginning of Relationship 96
b) HIV Discordance is Visible after Long Period in Relationship 98
7.4 Impact on Condom Use 99
a.) HIV Disclosed at the Beginning of the Relationship 99
b) Couples Who Knew of Discordance a Few Weeks/Months after Formation 101
c) Couples Who Became Aware in the Course of the Relationship 104

d) Condom Use during Oral Sex....107

7.5 Conclusions....108

CHAPTER 8: TAKING RISKS. GETTING FAMILIAR WITH THE VIRUS 111

8.1 Introduction....111

8.2 Last Time Condoms Were Not Used....112

a) Without Internal Ejaculation: When Discordance is Known at the Start of the Relationship....112

b) Internal Ejaculation without Condoms: When Discordance is Known within the First Months of the Relationship....115

c) Unprotected Sex in Couples Knowing their Discordance in the Course of their Relationship....119

d) Couples Who Have Always Used Condoms....123

8.3 Difference Between Wearing and Not Wearing Condoms....126

a) Difference in Emotional Connectivity with Partner....126

b) Difference in Physical Pleasure....127

c) Do not Know about a Difference....128

8.4 Reaction to a Hypothetical Scenario of HIV infection....129

a) Perception of HIV-negative Respondents....129

a.1) Fears of infection....130

a.2) Not Showing Fears of Infection....131

b) Perception of HIV-positive Respondents....133

8.5 Conclusions....136

CHAPTER 9: MEANINGS ATTACHED TO SEX 140

9.1 Introduction....140

9.2 Meaning of Sex in the context of the Partnership....140

a) Physical/Emotional....141

b) Companionship....142

c) Abandoning Oneself to Another....143

d) Sex as a Contract/Emotional Ties....144
e) Contract/Economic Ties....146
f) When Antiretroviral Decreases Sexual Libido....147

9.3 What would happen if there were no sexual relations?....148

9.4 Importance of Anal Penetration....151
a) Couples of Recent Formation....152
b) Couples in Long-Term Relationships....155

9.5 Meanings attached to semen....157
a) The Stories of HIV-Positive Men....158
b) The Stories of HIV-Negative Men....164

9.6 Conclusions....166

CHAPTER 10: CHALLENGES OF BEING IN A HIV-DISCORDANT COUPLE 169

10.1 Introduction....169

10.2 Perspective of HIV-negative Informants....169
a) Mood Changes....170
b) Fears of Infection....173
c) Who cares about me?....176

10.3 Perspectives of HIV-positive Informants....179
a) Possibility of Losing a Partner....179
b) Dissatisfaction with Sexual Life....182
b.1) Lack of Interest in Sex....182
b.2) Sex Has Changed for the Worse....183
c) Learning to Cope with the Disease....185
d) Responsibilities Surrounding HIV Transmission....187
e) Partner's Fears....188

10.4 Conclusions 189

CHAPTER 11: CONCLUSIONS **191**

APPENDICES **201**

Appendix A.1: Characteristics of HIV-Negative Men 201

Appendix A.2: Characteristics of HIV-Positive Men. 203

Appendix B: Cover Letter 205

Appendix C: Informed Consent Letter 206

Appendix D: In-depth Interview Guide 212

BIBLIOGRAPHY **217**

VITA **229**

List of Tables

TABLE 1: DOES RESPONDENT CURRENTLY HAVE A PARTNER? 55

TABLE 2: AGE GROUP BY HIV STATUS OF RESPONDENTS 55

TABLE 3: EDUCATION BY HIV STATUS OF RESPONDENTS 56

TABLE 4: OCCUPATION BY HIV STATUS OF RESPONDENTS 57

TABLE 5: TIME ENGAGED WITH THE PARTNER 57

TABLE 6: TIME RESPONDENTS ARE AWARE OF HIV DISCORDANCE 58

TABLE 7: TIME ELAPSED FROM DIAGNOSIS TO DISCLOSURE OF HIV TO PARTNER. 59

TABLE 8: TIME SINCE DIAGNOSIS WITH HIV (ONLY FOR HIV+ RESPONDENTS) 60

TABLE 9: LATEST CD4 CELL COUNTS (ONLY FOR HIV+ RESPONDENTS) 61

TABLE 10: VIRAL LOAD COUNTS (ONLY FOR HIV + RESPONDENTS) 61

Chapter 1: Introduction

This research will explore the meanings of sexual activity and condom use in HIV-discordant male couples in Mexico City, couples in which only one partner is HIV positive. For that purpose I will draw on 44 in-depth interviews with men in a current or past HIV-discordant relationship. The general motivation for this research is to explore the factors that influence sexual behavior and condom use besides knowledge about HIV/AIDS. In populations at risk for HIV infection, information and knowledge about the mechanisms of HIV/AIDS transmission and its prevention do not translate into consistent condom use or into sexual behavior that eliminates the risk of HIV transmission (Geringer et al., 1993). Empirical studies show that people practice unsafe sex even after learning about the risks of certain sexual behavior and the effectiveness of condoms to avoid any STD, including HIV/AIDS (Davis, 2002; Semple et al., 2001).

National campaigns to prevent HIV transmission have usually relied on providing information about the disease and, to some extent, on improving the skills to negotiate condom use (Carrillo, 2002; Rosenthal et al., 1998; Whitehead and Carpenter, 1999). Yet it is equally important to do research on the meanings that people give to sex in their everyday lives and to condom use because such research will also contribute to understanding the behavior that reduces or facilitates the transmission of HIV and other STDs.

The theoretical approach of the present dissertation recuperates interpretative perspectives (symbolic interactionism and phenomenology) within the social and cultural structures in which human action takes place. An important element of this approach is that the meanings people attach to things explain a great part of human behavior, and that such meanings vary from individual to individual due to situational contexts. According to these perspectives, meanings are created through interaction with others and modified through the course of subsequent action and interpretation (Blummer, 1969). Meanings have a social character as they are created and re-created through social interaction. The relationship of people with such collective or shared meanings depends on their individual experience. Different interaction between individual experience and social

processes will derive in different identities, which in turn will affect the ways that people appropriate collective meanings and behave toward things or events (Berger, 19670) (see theoretical chapter).

With this approach in mind, the first objective of this dissertation is to study the impact of HIV-discordant status in the sexual life of male couples in Mexico City, an area with the highest prevalence of HIV in Mexico. To achieve this goal I analyze whether there is a change in the frequency and type of sexual practices or condom use after couples become aware of their HIV discordance. My main interest here is to study whether awareness of HIV leads to protected sex in couples that did not use condoms in the past or whether it reinforces such practices in couples that already were practicing protected sex. In cases where protected sex is not observed whether regularly or occasionally I explore different reasons for taking risks that might lead to primary and secondary infection.

The second objective of the dissertation is to study the meanings that men give to sexuality in light of Mexican cultural values of romance and intimacy and such meanings' relationship with decisions of whether or not to use condoms to prevent HIV transmission or re-infection in HIV-discordant male couples. Here the analysis concentrates on the meanings attributed to different sexual practices, to bodily fluids, and to lack of condom use.

A third objective is to study different challenges that the interviewed couples face at the interior of their relationships due to personal adaptations to their HIV discordance and to social conditions that make that situation difficult. The purpose is to explore situations of vulnerability for both members of the couple and whether there is an institutional infrastructure to address their needs for health care. This effort can also lead to preventing an increase of HIV transmission in this population.

A fourth objective of this investigation is to study respondents' sexual identity and their processes of coming out. For this purpose, I explore respondents' personal stories of sexual initiation, their self-discovery of same sex attraction, and how and when they shared their sexual preference with other people. These stories are important because in many cases it is possible to trace the value that respondents give to different sexual

practices and to bodily fluids that will subsequently lead to unprotected sex. Along the same lines, I explore the context in which participating couples disclose their HIV status and the reaction and support offered by family and friends, as such reactions relate to the possibility of improving the quality of life for HIV-discordant couples. Because the purpose of this objective is to contextualize the population studied, this information is presented in the initial chapters.

This project is important because as new HIV-therapies and anti-retrovirals are developed to prolong the life of individuals with HIV/AIDS, the accumulated number of persons at risk of transmitting HIV/AIDS is increasing: by September 2006 approximately 182,000 persons were living with HIV in Mexico and in that year alone, 4,374 new cases were registered (CENSIDA, 2006). People at risk of HIV transmission require new interventions that promote long-term sexual changes to either protect themselves from re-infection (if they are HIV positive), or to protect their partners from primary infection (Kalichman, 1999). In Mexico those efforts are particularly important in MSM as estimates show not only a high prevalence of HIV (15%), but also demonstrate that many of those infected with HIV will have a partner at some point in their lives[1] (CENSIDA, 2005; Izazola et al. 2000). The results can also encourage future research, especially of a quantitative nature, to make assessments with health policy implications.

Unlike previous research, the present investigation fills a gap in the literature by interviewing both members of HIV-discordant couples rather than only one member and by identifying couple-level factors that contribute to unsafe sex (Remien et al., 1995). This approach is based on the understanding that sexual behavior that carries a risk for STD infection occurs in the interaction between at least two individuals, rather than in isolated individual behavior. As sex is social in nature it involves negotiation, expectations, and demands between the parties involved (Laumann et al., 1994).

The body of this dissertation is presented as follows. Chapter 2 presents the theoretical approach. It describes the premises of 3 approaches that to a greater or lesser

[1] Empirical studies estimate that 30% of active homosexual men have a stable relationship at some point in their lives (Izazola et al., 2000).

extent consider the creation and recreation of meanings in everyday life and their relationship to behavior. The chapter presents the basic concepts of symbolic interactionism (as described by Blummer, 1969), the social construction theory (Berger and Luckmann, 1967), and the social organization of sexuality (a melding of 3 theories presented by Laumann et al., 1994). Recognizing the existence of different levels to explain reality, this project chooses to focus on meanings to recuperate the voice of actors involved in risk-taking behavior, a task put aside by many theories in favor of structural and micro-social factors. As part of the cultural and social characteristics in which respondents have formed their identity and constructed meanings about things, this chapter also presents a brief view of Mexican ideals of romance, characteristics of family relations, and perceptions of masculinity.

Chapter 3 reviews empirical studies on sexual practices and the meanings attached to sexuality in HIV-discordant male couples. Most of the results refer to English-speaking countries. There is virtually no investigation on this topic for Mexico or Spanish-speaking countries. Nevertheless, the chapter presents some related research on sexuality in Mexico on homosexual and bisexual men regardless of their HIV or marital status.

Chapter 4 describes the materials and methods of the investigation, including some selectivity issues involving the men interviewed. It presents the selection procedure, data collection process, and analysis of the data. Chapter 5 describes the characteristics of men interviewed in terms of their HIV status, age, education, occupation as well as the time they became aware of their HIV discordance, whether it was since the beginning of the relationship or after having been together for some time. It also presents information about their sexual identity, the moment they realized their attraction to other men, and whether they have discussed this attraction over with their relatives or friends. For the HIV positive respondents, the chapter also presents their CD4 cell counts and viral loads, as well as contexts in which they have disclosed their HIV status to persons other than their partners. Throughout the body of the dissertation I use pseudonyms to refer to different informants. I omitted their real names to maintain the

confidentiality of their information. A list of these pseudonyms and characteristics of informants is presented in the section of Tables, right after the conclusions.

Chapter 6 focuses on when and how HIV positive respondents were diagnosed with the virus and their sexual practices at the time of probable infection. This information helps to trace some possible factors that facilitate risky sex in stable relationships and casual sex. The chapter also refers to the disclosure of informants' HIV status and the reaction of their partners, which works as a bridge to the topic of the next chapter. The analysis takes into account the moment which both respondents became aware of their discordance, whether at the beginning of the relationship or after some time of having been together.

Chapter 7 concentrates on the direct effect of HIV discordance on the sexual life of the couple. It answers the question of whether awareness of HIV discordance modified couple's sexual practices in terms of frequency, type, and level of protection or condom use. For this purpose I asked respondents to talk about their sexual practices before and after knowing about their HIV discordance. This analysis is based on general questions regarding sexual activity and condom use.

Chapter 8 gives answers to more detailed questions about the last time the respondents did not wear condoms during sexual activity. It allows me to identify risky situations that couples had not previously considered as such, situations in which contact with partner's bodily fluids had occurred: foreplay without condoms for anal or oral sex and withdrawal before ejaculation. The chapter also searches for respondent's reaction to a hypothetical scenario of HIV infection or re-infection, discerning whether respondents may be looking for this possibility or not.

Chapter 9 discusses the meanings that the men interviewed attached to sex in the context of a stable relationship and whether this meaning was associated with practices of risky sex. The chapter starts with a general question about the relevance of sex in the respondents' relationships and then proceeds to more particular topics such as the importance of anal intercourse and direct contact with bodily fluids (in particular the contact with semen). The analysis helps to explain why some men get involved in high-risk practices regarding HIV infection and re-infection.

Chapter 10 explores the issues that respondents consider challenging in their HIV-discordant relationships, showing the need for institutional programs that attend to the needs of both members as a couple, rather than focusing on the patients as units isolated from any intimate relationship and disregarding their uninfected partners. Chapter 11 summarizes the results of all chapters and makes some reflections on the implications of these findings for future research and for health programs that focus on HIV-discordant male couples. It also presents some limitations of the study.

The last part of the dissertation includes the appendix section (characteristics of informants, invitation letter, informed consent letter and the interview guide), the bibliography section and a short personal vitae.

Chapter 2: Theoretical Approach

> 'If men define situations as real, they are real in its consequences' (Thomas and Thomas, 1928: p. 572)

2.1 Introduction

The premise of this research is that an important component of sexual behavior is explained by the meanings that people attach to it. Meanings are created and modified through interaction in everyday life, and they subsequently become part of a social web of meanings, or norms and values of things. The idea is that individuals encounter a set of meanings in which action takes place, but individuals also contribute to the re-creation of meanings through their everyday interaction and through their interpretative capacity. Such interactions include their own actions as well as others' reactions. This approach is important because it recognizes that human behavior is in part influenced by social and cultural relations, and it also recognizes that individuals have an interpretative capacity over things that affects their own and others' behavior.

I choose this perspective because I want to focus on the ways which people who are aware of their risk of HIV transmission or re-infection perceive their sexual lives. I want to analyze how discovering HIV discordance becomes a meaningful event for each member of the couple and whether and to what extent such awareness affects their sexual practices. I also assume that the perceptions that participants have about their current situation as HIV-discordant couples derive from the personal processes of interpreting various issues like illness, sexuality, and condom use. In addition, I consider the couples' mutual interactions on these and other issues, including their perceptions of their partner's attitudes and expectations of the relationship.

It must be mentioned that the interaction of the couple regarding their sexual life does not occur in a vacuum. It instead occurs within a set of social relations and cultural values that sets the tone for participants' creation and recreation of meanings and for their interaction within the couple, as well as with other members of society. Nevertheless,

symbolic interactionism confers to individuals the capacity of not circumscribing their behavior as the exclusive effect of social and cultural factors. Individuals' interpretative capacity confers upon them the ability to decide upon certain courses of action.

In the following sections I would like to expand on the basic premises of symbolic interactionism as well as demonstrate some of its problems. I will also talk about other sociological approaches and how these share similar concerns with symbolic interactionism, although they give slightly different weights to the role of social and cultural factors. Because in all of these perspectives social relations and cultural values set the tone for human behavior, I would finally like to summarize the general context in which participants' actions take place, as well as the process of creating and re-creating meanings in Mexico.

2.2 Symbolic Interaction Perspective

One of the main proponents of symbolic interactionism is Herbert Blummer. He recuperates and gives a more coherent shape to Mead's ideas about self and self-interaction. But he also deepens previous work, especially involving concepts like interpretation, meanings, structure and process (Wallace and Wolf, 1999).

In *Symbolic Interactionims. Perspective and Method* (1969), Blummer summarizes the methods and basis of this theory. The three main premises can be described as follows:

a) "Human beings act toward things on the basis of the meanings that the things have for them" (Blummer, 1969: p. 2). This posture is a reaction against behaviorism, the idea that human behavior is explained by mechanical stimulus-response approaches, excluding interpretation. I use this premise in the present research, and argue that symbolic interactionism would be opposed to theories that explain human sexual behavior based exclusively on physiological or biological factors. Instead, an interactionist approach would consider how people define a series of things or events related to sex and the consequences of such definitions on their subsequent behavior.

With this premise Blummer also defies sociological postures that confer to the following structural factors total explanatory power over human behavior: social roles, cultural prescriptions, and social structure. According to Blummer, these categories of analysis disregard the interpretative process of human beings toward the things they are acting upon and the consequences of their actions. Once again, the individual's interpretative process over things is crucial regarding his or her behavior.

b**)** "The meanings of such things is derived from, or arises out of, the social interaction that one has with one's fellows" (Blummer, 1969: p.2). This claim stands in contrast to beliefs that meanings arise from the nature of things or through the psyche of individuals. With this premise Blummer identifies the source of meaning as social, not individual. In the case of the present study, the interactions of respondents with their partners, as well as with friends and family help to provide meanings to issues related to relationships, intimacy, sexual interactions, protections and illness. Such interactions will also be responsible for a variety of respondents' courses of action.

Individuals acquire and recreate social meanings through interaction in general and socialization (Ritzer and Goodman, 1996). For this reason, the present research also explores important events during childhood and adolescence which made respondents realize their sexual orientation and had an impact upon their sexual life.

c) "These meanings are handled in, and modified though, an interpretative process used by the person in dealing with the things he encounters" (Blumer, 1969: p 2.). According to Blummer, this process of interpreting meanings involves two phases: one in which a person or actor identifies the things that are involved in his acting and initiates a process of communication with himself; and second, the actor selects and transforms the meanings conferred socially to things depending on the situational contexts in which he is located. The implication of this posture is that individuals do not blindly use external meanings as guides for their actions; instead, they change such meanings based on their own reflexive processes and contextual situations.

A strength of this approach is that it helps to understand people's actions as not totally determined by social and cultural structures. Although Blummer recognizes some regularity or repetitiveness in social interaction and consequently the relevance of structure to actions, he thinks that such regularity derives from the common definitions that individuals have of things, and he focuses on the study of the contingent elements of interaction and how subsequent actions derive from them. He does all this from the point of view of the actor.

Symbolic interactionism recognizes that a portion of human action cannot be totally predicted and that its course depends on an interpretative process within social interactions. Its use is specially suited for the study of unprecedented or problematic situations (as it pertains to the study of HIV discordance) where behavior cannot be "spelled out before hand" (Wallace and Woolf, 1999: p. 215).

Perhaps one critique of Symbolic Interactionism is that it overemphasizes the study of meanings, leaving in second place the study of social structure and social change (Meltzer et al., 1975). For the present study, I do not see such omission as problematic because the dissertation's basic idea is to recuperate what has been left aside by many studies: the voices and perceptions of people living with the virus and those who are at direct risk of transmission. Without denying the importance of greater macro social and structural aspects, I leave for future research their more careful consideration. In the present dissertation I make reference to social and cultural characteristics of Mexico as the background in which respondents' lives take place, but I concentrate on other relevant issues: the question of how people perceive events or things and how such perceptions might affect their behavior.

2.3 Social Construction of Reality

Other sociological approaches have also analyzed the relevance of meanings to understanding everyday life. Labeled by some as a branch of symbolic interactionism and by others as a part of phenomenology, the social construction of reality approach shares with the previous approach the analysis of meaning to understand everyday life. Under

this new perspective reality is socially constructed through a continuous process of action and interaction. It is through such processes and face to face interactions that people make sense of reality as subjectively meaningful, that is individually appropriated, and objectively factual, that is represented by institutions and social order (Wallace and Wolf, 1999).

According to social constructionists, the subjective experience of reality is not limited to individual experience because perceptions of reality also contain elements that are shared with others. The result of this dialectical dynamic between individual experience and social processes is the particular **identity** that individuals acquire. According to Berger and Luckmann (1967), identity is created and reshaped through social interaction, and, at the same time, affects the social structure. Particular identities also help to illuminate particular meanings that people give to events or situations framed by their own historical and cultural context. For this reason this concept is important to the present research, as it can shed light upon how the men interviewed experience their life as MSM involved in an HIV-discordant relationship, which has particular implications about their sexual lives.

According to this approach, there are three moments of special importance in the social construction of reality. The first moment is called **"externalization,"** and it occurs when individuals contribute to the creation and recreation of their own social world through their interactions with others. In my research, such externalization could be exemplified by the emergence of a new relationship with a sexual partner and, through time, with the development of expectations of obligations and rights for the maintenance of the relationship. This approach highlights in the ways that individuals are capable of creating new social reality, and, through ongoing interaction, how they can contribute to that reality's maintenance and recreation.

A second moment in the social construction of reality occurs when individuals perceive reality as pre-established and subsequently act upon it. This phenomenon is termed **objectivation**. In the case of HIV-discordant couples, objectivation would be the way in which the status of a couple impacts the actions of each participant given that they have to react to a particular situation depending on their own status.

The third moment in the social construction of reality occurs when individuals internalize the expectations of the social institutions that they help to create or recreate and that act upon them. **Internalization** in this sense is similar to the concept of socialization and is exemplified when individuals decide to meet the expectations of the social order that they also experience as external to them. In researching the sexual and intimate dynamics of couples, internalization is expressed when participants do things for their partners because participants believe that such cooperation is what having a partnership fundamentally means.

The importance of this perspective is, like symbolic interactionism that Blummer spells out, that it studies everyday life through the creation and recreation of meanings as a social process. Its basic premises inform this dissertation's analysis; I place particular emphasis on the idea of meaning and identity. These premises complement Blummer's premises with regard to the construction of meanings and their relationship to behavior.

2.4 Social Organization of Sexuality

Laumann et. al. provide a more specifically sexual framework of the social construction theory in *The Social Organization of Sexuality* (1994). In this book the authors combine three theories to explain sexual behavior: the scripting theory, the choice theory, and the network theory. Despite the different names and concepts, the blending of these theories (made by Laumann, Gagnon, Michael and Michaels) share with symbolic interactionism and social construction of reality the consideration of three levels of analysis to understand human behavior: cultural, social and individual.

The scripting theory resembles somewhat the symbolic perspective in that it also refers to three dimensions in which human behavior takes place. Scripting theory labels such dimensions as cultural scenarios, interpersonal scripts, and intrapsychic scripts. The theory assumes that locally-derived culture provides a set of common instructions for sexual behaviors, including the definition of what is considered sexual, what is appropriate to do, and with whom it is appropriate to do so (Laumann and Gagnon, 1995). The interpersonal scripts refer to how social interaction in everyday life influences

behavior, and intrapsychic scripts refer to the individual fantasies and desires that guide behavior and that manage to change cultural scripts or to accommodate them according to an individual's personal experience. As traditional interactionists, Laumann et al (1994) consider that individuals guide part of their sexual behavior through a process of interpreting cultural narratives in their interaction with others.

From the choice theory, Laumann et al. (1994) revive the idea that humans behave on the basis of goals they have. In the context of sexual behavior in particular, the authors mention that such goals could be sexual gratification, emotional satisfaction, desire for children, desire to become popular with friends, and so on. This idea intersects with the intrapsychic component of the scripting theory, which dictates that individuals have fantasies or desires that guide behavior. The choice theory also considers a social aspect in its explanation of human behavior because it takes into account that the efforts of one person to achieve his or her goals affect others' goals. This assumption is similar to the symbolic interactionist's perspective: an individual's actions are affected by others' reactions, as well as by what he or she perceives about others' perceptions of those actions. In our current research, for example, we could think that the efforts of a respondent to use condoms affect or are affected by the partner's desires regarding how to have sex in a specific moment.

According to Laumann et al. (1994), the social component is better reflected by the network theory, as it assumes that sexual interaction is a special case of social interactions in three ways. First, it involves at least two individuals. Second, the patterns of partnership conform to broader patterns of social relationships: who has sex with whom and how relationships are maintained. Third, when and how to have sex is a transaction that occurs depending on the particular characteristics of the partnership: sexual dyads are influenced by larger networks.

The network theory stresses the importance of analyzing actions within relationships, rather than focusing upon individual acts or persons. For this reason it requires of the scripting theory or the choice theory that they provide an understanding of what motivates individuals in their behavior. While the scripting theory explains the

structure of the events, the network theory explains the structure of the relationships among persons.

Like symbolic interactionism and the social construction of reality, the framework provided by Laumann et al. (1994) supports the consideration of different levels of analysis. My analysis has taken such levels into consideration, but due to limits of time and resources it concentrates on the perceptions of respondents on their particular situation as HIV-discordant couples, leaving others aspects for future research (like the study of more extensive social networks). For this reason, it constantly refers to the premises of symbolic interactionism or the concept of identity (from Berger and Luckmann, 1967) when discussing the results.

2.5 Socio Cultural Characteristics of Homosexuality in Mexico

As indicated by Blummer and Berger the source of meanings is social. Meanings are originally produced during face to face interactions, and they become a cumuli of knowledge that serves as the context in which individuals take action and recreate old meanings. In other words, to understand the significance that people attach to their sexual lives in the context of a relationship, we must also know the cultural norms and social relations that prevail around them. With this purpose in mind, the following sections present the main cultural and social characteristics of Mexico that are relevant to understand the sexuality of MSM: social definitions of love, family loyalty and sexual silence, and attitudes towards non-heterosexual behavior.

a) The Idea of Love and Romance

In Mexico, as in any other country, cultural values and norms about sexuality and love affect how people feel and behave in intimate relationships. Traditionally, sexual activity is prohibited outside marriage or any other socially approved relationship, with different gradients of enforcement depending on gender. Nevertheless, people tolerate breaking those normative rules if sexual activity is the result of love and commitment

(Carrillo, 2002). Although this includes heterosexual relationships, the association between sex and love also reaches long-term or stable relationships between MSM.

In a study with heterosexual and homosexual men and women in Guadalajara City (Mexico), Carrillo illustrates that for most participants, sexual intercourse is an emotionally and spiritually meaningful event. This sense of meaning is the result of cultural scripts that link love and sexuality as well as the particular forms in which individuals appropriate such scripts based on their own experience. Carrillo indicates that, in certain contexts in Mexico, the socially created need to experience love leads to different social scenarios: sometimes individuals try to convince themselves and the people around them that they are in love to justify sexual desire or intercourse, which is socially determined love; other times their behavior follows a process of infatuation that he calls "real love," and such love is more the result of individual desire. In both cases people feel compelled to express their love by trusting their partners and doing things they would not normally do. Some of those things, for example, can include having sex against one's own personal will to comply with a partner's desire, or having unprotected sex in spite of potential risks of pregnancy or exposure to STDS. Similar situations are also present in research about other countries (See next chapter). Carrillo concludes that developing trust is a major ingredient that determines priorities and decisions about sexual intercourse.

Research in Hermosillo, Sonora, introduces a different element to the understanding of intimate relations of MSM. Nuñez-Noriega (1999), for example, concentrates his study on the different representations and sexual arrangements of middle-class men with a homosexual identity. One of his findings is that romantic relationships between men may not last long due to the similar process of socialization that men experience which leads to competition rather than to complementariness. Values of independence, dominance and freedom are barriers to consolidating long-lasting relationships among MSM. These results lead one to wonder about the form that affection and trust can take in these particular forms of interaction.

The two perspectives also lead to further avenues of research in same-sex couples: focusing on the particular contexts of trust and intimacy developed in same-sex couples.

A particular line of inquiry is to discover whether in Mexican same-sex couples sexual and affective interaction express in the form of social commitment and self-sacrifice (following the cultural scripts that Carrillo indicates), or rather in the form of individualism and independence due to the male characteristics of both partners. It is also important to see whether any one of these forms of interaction lead to unprotected sex in couples who are aware of their HIV-discordance.

The studies just mentioned provide important clues to understanding sexual behavior in Northwestern Mexico. Nevertheless, these studies only include information from one individual and are not set up to analyze HIV-discordant couples. To my knowledge there is practically no research on this sub-population in Mexico.

b) Familism and Sexual Silence

For interaccionist theorists, individuals are not born members of a society. They instead learn to become members through a process of internalization of reality and socialization. Through these initial processes individuals learn the shared meanings attached to events or things on which they will make their own interpretations and will make reality subjectively meaningful to themselves (Berger, 1967: p. 129). One first place individuals are socialized is the family. In the family, individuals will first learn the social construction of gender and sexuality (Cantu, 2002), as well as the roles and attitudes expected from each actor.

In the case of the Mexican family, loyalty among its members is an important value. For Mexicans, as for members of US Latino cultures, there is a strong sense of respect and obligation to the family of origin. Family is an institution that provides support and protects individuals from economic or social adversity; it also conveys responsibilities and obligations to other members of the family. For many MSM, family can also mean constraints over their sexual or personal life. Open discussion of sexuality or recognition of homosexuality in one of its members is not common in Mexican or US Latino families. To avoid any conflict and to receive continued support from the group, sexual behavior that transgresses tacit norms of normality remains hidden (Carrillo, 2002; Diaz, 1998; Carrier 1995).

In many instances, homosexuality is tolerated to the extent to which it remains hidden. Some family members may know or suspect the homosexuality of one relative, and, in turn, this relative may assume that others know about his or her homosexuality, but in any case they do not openly talk about the topic. This pattern leads to an implicit culture of don't ask/don't tell which allows for tolerance and respect as long as there are no overtly visible behavior or comments that transgress expectations of normality.

For Carrillo (2002), sexual silence may contribute to a cultural representation of sexuality in a positive way: as it adds "spiciness" and excitement to the performance of sexual activity by transgressing social norms and "flavoring" sexual passion and desire. For Diaz (1998) and Carrier (1995), in contrast, sexual silence has negative consequences for the representation of sexuality and the way it is enacted by individuals. Sexual silence leads in many cases to dissociation of family relationships from gay friendships, creating two separate worlds in the life of homosexual men. Such dissociation usually translates into a disconnect between affections and sex in a context of personal shame and dissatisfaction (Nuñez-Noriega, 1999; Diaz, 1998). Such a disconnect leads many men to simply look for anonymous sex while intoxicated and to practice unsafe sex, increasing their risk of HIV transmission. Dissociation between affection and sex may also lead to strong longing for love and romantic partnership in the context of loneliness and absence of affective intimacy.

It is interesting to note that such dissociation between affective ties and sex does not occur in the couples' I interviewed. In the present research informants define themselves as "stable couples," and they have positive expectations about their relationships, among which satisfaction of emotional needs in conjunction with physical pleasure are important ones. Like everybody else, informants assume that their role as partners is to provide and receive affection and sex within the couple.

Strong reliance on family support also affects the establishment of a well-developed gay community that could help MSM with processes of self-acceptance and self-regulation with better effects on safe sexual behavior (Diaz, 1998; Carrier, 1995). Diaz's and Carrier's studies mainly look at individuals that engage in anonymous sex and that lack the possibility to develop intimate relations. Whether their results also apply for

people engaged in stable relationships is a question that deserves further investigation. Inquiries for future research should illuminate the extent to which familism and sexual silence also affect sexual behavior of same-sex couples, as well as the degree to which these couples are inserted into regular family relations: how do they manage the homosexual nature of the couple and the HIV-discordant status with their families? Do families provide special support due to the sexual orientation or the HIV-discordant status of the couple?

c) Attitudes towards non-heterosexual behavior

Current expressions of masculinity in Mexico City defy, in some contexts, the traditional stereotype of Mexican machismo[2]. New male identities are the result of a series of processes connected to modernization and globalization: the transformation of sexuality due to an increased control over reproduction; the gay rights movements in 1970-1980's; and the increased participation of women in education, labor market, and political activities that resulted in struggles against gender inequality (Gutmann, 1996).

Such changing conceptualizations of sexuality, gender relations, and tolerance for diversity reinforce recent critiques of the concepts of macho/machismo as something inherent and universal among people belonging to Latin American cultures or United States Latino cultures (Gonzalez-Lopez & Gutmann, 2005). Research on popular areas of Mexico City shows that there is not a monolithic form of thinking or behaving that could be universal among all men or women in Latin American countries (Gutmann, 1996). Men of different social backgrounds even refuse to use the term machismo because it does not portray their attitudes toward gender relations and sexual tolerance. Even in cases in which men identify themselves as macho, they don't always adopt the negative aspects of the concept, including abusive behavior and intolerance about non-heterosexual behavior; they instead allude exclusively to the positive characteristics of the concept: fulfillment of men's responsibilities as they are socially created towards family and other (Gonzalez-Lopez & Gutmann, 2005; Gutmann, 1996).

One of the consequences of the process of modernization and globalization is that people have conceived sexuality as a malleable entity with different possibilities of expression (Gutmann, 1996). There is no one specific and absolute form that portrays the ideal of manhood, but new representations now co-exist with old ones. For example, at the same time that men started spending more time with their children and doing activities previously considered as exclusive of women's domain (Gutmann, 1996), research found that some men still associate masculinity with strength and womanizing behavior (Stern et. al., 2003). Translated to the area of sexual tolerance, the coexistence of diverse conceptions of masculinity imply more tolerance towards different sexual behavior and the existence of layers within society in which non-heterosexual behavior is not totally accepted. For example, Stern et al. (2003) found that in marginalized areas of Mexico City male teenagers report tolerance to homosexual men, but they still consider homosexuality as an antisocial behavior, and they impinge upon it negative connotations. That is, they express homophobia. It is common to hear expressions that make fun of homosexuals and that convey exclusion and marginalization. This phenomenon occurs even though other research has found practices of same sex between heterosexual teenagers as a form of sexual experimentation or as a transitory stage to adulthood (Gutmann, 1996).

For people who still endorse values of courage, strength and risk-taking as characteristics of masculine behavior, female features are devalued when present in men. In this particular conception of manhood, maleness is not a given, it is one extreme on a continuum that every man must prove he meets on a daily basis. Men who do not observe the most valued norms with regard to manhood are considered "not real men," and people generally include under this category MSM, especially if they do not self-identify as heterosexual (Rodriguez and Keijzer, 2002; Amuchastegui, 2001; Diaz, 1998; Murray, 1995; Carrier, 1995).

According to Diaz (1998), particular conceptions of manhood and negative attitudes toward non-heterosexual behavior have important consequences for the way

[2] Machismo: term used in academic literature to refer to male abusive attitudes associated to gender inequality. Like the term macho, it has also been used uncritically to ascribe it automatically to Latin

men perceive their sexuality and on whether they observe any practice to avoid HIV transmission. If men believe they are hyper-sexual and have limited self-control, then such beliefs can become a barrier to safe sex.

In marginalized areas of Mexico City, the focus on penetration derives from strong endorsements of erection as a phenomenon that fits the model of masculine behavior, especially among those who portray heterosexual identities (Diaz, 1998; Prieur, 1998 and 1996). The fear of losing an erection makes many men refuse to use condoms. The loss of an erection could be interpreted as an inability to play a masculine role (the active role during sexual intercourse), and to be identified as a man who only likes to be penetrated, something that is unaccepted in certain social contexts. The public health consequence of strong endorsements of heterosexual identity in MSM is that they are less likely to perceive themselves at risk of STD's and subsequently less likely to wear condoms. In extreme cases, shame about their same-sex desires induces men to use alcohol prior to initiating sexual activity. This pattern has a negative effect because it reduces the possibility that they will practice safe sex. In addition, their strong focus on penetration limits them from any opportunity to explore other sexual practices that carry less risk of HIV transmission (Diaz, 1998).

The previous conclusions mainly refer to men who do not self-identify as homosexual and who do not maintain long-term relationships for fear of being stigmatized. This fact makes pertinent the following questions: To what extent have men involved in same-sex relationships internalized stereotypical conceptualizations of masculinity, such as macho and machismo, as well as homophobia? How do these internalizations shape condom use, intimacy, and safe behavior in HIV-discordant couples?

These questions are pertinent because some research has presented the idea that machismo and patriarchy are inherently Mexican and Latin American, and that these qualities pervade all aspects of life in these countries, even homoerotic encounters, not to mention all relations between men and women (Gonzalez-Lopez & Gutmann, 2005). In addition, research has uncritically transported binary models of gender

---

American culture as something universal and innate (Gonzalez-Lopez and Gutmann, 2005).

(masculine=power=active vs feminine=weakness=passive) to relations between MSM. Such stereotypes have been proven to fail in providing deeper understanding of social relations among MSM in Mexico (Nuñez-Noriega, 2001).

The "Mexican- Latin American" or "Mediterranean" model (synthesized by Almaguer, 1996) is one of the conceptual approaches that have been traditionally used to understand all relations between MSM. Based on empirical research done by Currier, Parker, Lancaster, Adam, and Taylor in Latin America, Almaguer provides a conceptual model for the Mexican-Latin American sexual system. The premise of this model is that homosexual behavior is based on a differentiation between an active/penetrative role and a passive/receptive role. This differentiation synthesizes a gender/power configuration of the society. According to Almaguer (1996), the cultural construction of homoeroticism in Latin America assigns excessive value to anal penetration versus other practices: he indicates that the homosexual world in the Latin American model is strongly divided into "pasivos" versus "activos" (and he refers to Mexico and Brazil as good examples). Almaguer also indicates that power and stigma are not distributed equally among MSM. Because sexuality in Latin America is defined by the purpose of desire versus the object of desire, as it would be defined in the US and Europe., in Mexico and Latin America only the person that plays a passive/receptive role is subject to discrimination, while the person who plays an active/insertive role may even legitimize his masculinity.

This Latin American model of sexuality is emblematic of groundbreaking research projects examining sexuality in the social sciences. However, this model has been criticized by recent research, which has found that the meaning that MSM give to their sexual behavior may not correspond to patriarchal/phallocentric schemes. Men that play a "passive/receptive' role (even if these roles are exclusive), do not necessarily find themselves in a disempowered position regarding their partners. For example, they could experience an empowering feeling when confirming their seductive capacity. It should also be taken into account that regardless of gender or the existence of binary divisions, relationships are not always affected by power dynamics. In many cases, power relations affecting the interior life of the couple do not seem to be very clear cut or predictable (Nuñez-Noriega, 2001).

When power inequalities are present during sexual interactions, the flow of such power is neither unidirectional nor reduced to the Latin American model. The binary dichotomy between masculine-active and feminine-passive roles is not sufficient to help us understand the dynamics between MSM. There are also other elements that play a role and increase the complexity of the picture: differentials in educational achievements, access to economic resources, facility with language, and citizenship status should also be taken into account. Gonzalez-Lopez (2005) refers to the case of Mexican migrant workers who within heterosexual contexts may be privileged to exercise power over others, but while working for white/middle class/gay men in the United States may become sexually vulnerable. If in general gay masculinities are subordinated masculinities when compared to heterosexual masculinities, the socio-economic situation of white middle class gay men placed them at an advantage over men that in many cases are self-identified as heterosexual. Such unequal situations can also lead to what it is called the commoditization of sexuality: a commercial sexual transaction between migrant men and white men in unequal terms. Similar situations occurred between rural immigrants to Mexico City and middle class men (see Gutmann 1996: 127).

Anal penetration is not the only aspect in sexual encounters taking place between MSM, other important dimensions are involved in these encounters. Even in cases in which there are sexual transactions that include anal penetration, people do not conform all the time to one particular dimension of the active-passive dichotomy, and these encounters are not necessarily associated with masculine versus feminine characteristics. Such encounters may even occur contrary to what the patriarchal model would predict (feminine men penetrating masculine men, for example (Prieur, 1998: p 204-205). The characteristics of the sexual encounter vary depending on different circumstances that include particular desire at a particular time, willingness to satisfy the partner's desires, and so on. And couples do not necessarily conform to masculine and feminine roles within a relationship. In addition to making invisible an important range of sexual practices that occur between same gender participants, previous patriarchal paradigms that study homoerotic relations reproduce old schemas of gender that they were supposed both to illuminate and to combat.

Another critique of the Latin American model of sexuality it the emphasis it places on the lack of social stigmatization that active/masculine men receive in their communities, assuming that only men play this role in sexual encounters. Cantu (2002) indicates that poor men from small towns in several states of the Mexican Pacific Coast have problems succeeding economically in their communities. Such difficulties then force them to migrate. Since these men do not follow the hetero-normative expectations of getting married and having a family, their behavior creates gossiping in the town about these men's sexual orientation (even if they could 'pass' as 'masculine' men), making them susceptible to even fewer opportunities to succeed on their jobs or economically in general. Given situations such as this, the idea of a lack of stigmatization should be analyzed more carefully.

Chapter 3: Review of Empirical Literature

3.1 Introduction

The first section of this chapter will review epidemiological studies about the sexual practices reported by HIV-positive men, and, when possible, their male partners who are mostly HIV-negative or of unknown status. It will focus on the frequency and type of sexual activity (anal intercourse and oral sex), the consistency of condom use, and the different risk practices with a stable partner versus casual partners. As scientific information on sexual behavior of HIV-discordant male couples is scarce in Mexico and Spanish-speaking countries, much of the information cited refers to HIV-discordant male couples in English-speaking countries or to homosexual men not involved in a relationship at the moment of the interview.

Despite the socio-economic and cultural differences between Mexico and the countries cited, the information provided is pertinent because there is no evidence that in Mexico people practice safe sex to a greater degree than they do in other countries. The purpose is to show that in spite of knowing the risk of HIV transmission, people continue to engage in sexual practices that involve the direct exchange of bodily fluids and the consequent possibility of HIV infection. The second section of this chapter will explore some of the reasons that usually lead to unprotected sex; I pay particular attention to the meanings of sex and condom use. Here again, most of the studies reviewed correspond to English-speaking countries, as there are few studies in Mexico that address this particular issue. Finally, the third section summarizes all findings leading to the core research questions and objectives of this project.

3.2 Sexual Practices in HIV-Discordant Male Couples

a) Frequency of Sexual Activity

Studies with male couples in English-speaking countries show that right after the notification of the HIV-positive status of one partner, sexual activity decreases considerably—whether the activity is anal or oral intercourse (Higginbotham et al., 2000;

Remien et al., 1995; Palmer and Bor, 2001). They report an important loss of libido due to fears of infecting the partner and the decision not to have sex ever again (Sandstrom, 1996). In the long run, however, discordant couples resume sexual activities and remain sexually active in large proportions (Kalichman et al., 2002).

In Mexico there are no studies that focus on HIV discordant male couples as the unit of analysis, but studies with homosexual and bisexual individuals attending STD clinics in Mexico City report a considerable proportion of respondents having sexual relations at some point in their lives with a person infected with HIV/AIDS: around 10% of respondents reported this. In six Mexican cities (the most populated or those with higher levels of tourism), the proportion was much reduced: around 2% of the sample (Izazola-Licea et al., 1995). Nevertheless, these studies did not have the explicit purpose of analyzing the sexual behavior of HIV-discordant couples, so it is not possible to know if respondents were having a stable relationship or knew the HIV sero-status of the person infected with HIV/AIDS. From this lack derives the need for more studies about the sexual practices and risks of HIV transmission (or re-infection) in male discordant couples.

b) Anal Intercourse and Condom Use

Studies of HIV-discordant male couples in English-speaking countries indicate that anal intercourse and lack of condom use are common practices. In interviews conducted in the US with 15 HIV-discordant gay men couples, anal intercourse was reported in almost half of the cases (7 couples). Although the majority of couples reported using condoms on a regular basis, there were some couples that decided not to use condoms at all. Instead, they privileged intimacy and pleasure and decided to reduce the risk of HIV transmission by avoiding ejaculation or by having the HIV-negative partner play the insertive role (Remien et al., 1995).

Some studies also report higher sexual activity of individuals infected with HIV as compared to non-infected individuals. A sample of HIV-positive gay men from 7 US states and British Columbia, Canada, reported more unprotected anal intercourse with primary and casual partners in the preceding 3 or 4 months, when compared with HIV-

negative gay men. HIV-positive men also reported being involved in a relationship more frequently than HIV-negative men: they reported being engaged in a stable relationship or having no primary sexual partners more frequently than HIV-negative men (Kalichman et al., 1997).

In other studies of gay men attending clinical facilities in Seattle, Washington, and who had a high incidence of bacterial STD's, a substantial proportion engage in receptive anal intercourse (71.6%) or insertive anal intercourse (62.5%) with a main or casual partner. Almost half of the respondents reported having had sex with an HIV-negative partner or a partner of unknown HIV status, and 33% of respondents never used condoms with main or casual partners in spite of the consequent high risk of HIV transmission or re-infection (Whittington et al., 2002).

In Mexico I found only one study of gay couples as opposed to individuals, although the couples were not HIV-discordant. The study indicates that a high percentage of respondents do not wear condoms (without indicating the actual number), due to a general tendency to believe in monogamy and faithfulness (Cruz-Sierra, 2001). Contrary to respondents' own beliefs, the study indicates that 27% of respondents reported at least 1 event of casual sex in the last six months outside the couple. This study was based on 104 gay couples in Mexico City; the majority of them are middle class, have college or graduate education, and have been together four years.

Other studies in Mexico reported on individuals, rather than couples. Using a household probability survey in Mexico City, one study reports anal intercourse as a common practice: 32% of the sample reported anal insertive sex and 56% anal receptive in their last sexual encounter. This study also reports large proportions of the interviewees not using condoms: only 50% of the sample reported condom use in last sexual intercourse for anal insertive sex and 65% for anal receptive sex (Izazola-Licea et al., 2000).

Studies with homosexual men attending STD clinics in 3 Mexican Cities (Mexico City, Morelia and Puebla) also indicate that many respondents practice anal intercourse (37%) and that only a small proportion use condoms in all their sexual relations (21%). This sample had high prevalence of HIV (18%) and other STDs (34.9% syphilis, 28.6%

hepatitis) (Valdespino-Gómez et al., 1995). However, the study does not provide information about the type of relationship with the sexual partners or about mutual knowledge of the partner's HIV sero-status.

Information from homosexual and bisexual men attending an HIV/AIDS clinic in Mexico City shows that only 7.5% reported not practicing anal intercourse. Regardless of sero-status, the majority of respondent did not use condoms consistently; only 6 percent used it all the time in insertive anal intercourse, and 5 percent required it all the time with a partner in receptive anal intercourse. Although these results are not representative of MSM, they point out the risks existing in one sector of this subpopulation. In this sample 21% of bisexual men and 31% of homosexual men were HIV-seropositive. The study uses the individual as the unit of analysis, and it does not provide information for the couple (Hernandez et al., 1992).

Another study with homosexual, bisexual and transvestite men in Juarez City, a Mexico-US border city, reports that all respondents practice anal intercourse. Only 45% of respondents reported frequent condom use during anal intercourse and 27% never used condoms (Ramirez et al., 1994). This study, however, does not tell us anything about the HIV status of the informants or about couple-level variables.

c) Oral Sex and Protection

Unprotected oral sex is also a common practice among HIV-discordant couples. Studies in the US report oral sex among gay men as a regular practice. In most cases, people perceive oral sex as a practice of low risk for the transmission of HIV so condoms are usually not used. In a study with 15 discordant couples in New York, two thirds did not use condoms during oral sex. When there is concern about the transmission of HIV, oral sex is mostly practiced in one direction: the HIV positive partner is the only one giving fellatio to the negative partner (Remien et al., 1995).

In Mexico, studies of individuals who do not necessarily have HIV show similar findings. Homosexual men living in Mexico City report a frequent practice of oral sex: 46% of respondents practiced oral insertive sex and 41% practiced oral receptive sex during last sexual intercourse. At the same time, very small proportions of respondents

used condoms during last sexual intercourse: only 11% for oral insertive sex and 17% for oral receptive sex (Izazola-Licea et al., 2000). In Juarez City, 83% of interviewees (homosexual, bisexual and transvestites) practiced oral sex while 60% never used condoms (Ramirez et al., 1994).

d) Sexual Activity with Primary Partner versus Casual Sex

The type of relationship between partners is also important in understanding unprotected sex among HIV-positive individuals. Many studies report that lack of condom use in HIV discordant couples is observed more often in long term relationships than in casual relationships (Doll et al., 1997 cited in Kalichman, 1997; Davis, 2002; Moreau-Gruet at al., 2001; Gold et al., 1994). A study in the US, for example, shows that HIV-positive individuals report a greater frequency of condom use with discordant irregular partners than with discordant regular partners, which results in greater transmission rates to regular partners than to irregular partners among certain populations (Kalichman et al., 2002: this sample is mostly African-American, with a high proportion indicating that they are gay or bisexual 64%). Other studies report different findings: no association between relationship status and unprotected sex in HIV-positive individuals. For example, among heterosexual and gay samples recruited in infectious disease clinics and AIDS service agencies in the state of Georgia, high risk practices were not limited to long term relationships or to partners who were also HIV-positive; HIV-positive respondents also practiced unprotected intercourse with casual partners or HIV-discordant partners (Kalichman, 1998).

In Mexico there is little information on this topic for male couples. Izazola et al. (2000) report that 58% of homosexual men used condom in their last sexual encounter with a steady male partner, while only 30% did with a casual partner. For heterosexual men, Hernandez-Giron et al. (1999) report opposite patterns: condom use in their last sexual intercourse with a regular partner is lower (36.7%) than with an occasional partner (62.5%). Although in this study reasons for using condoms are totally different than in homosexual men, as opposed to STD prevention, heterosexual men with a regular female partner reported condom use to avoid an unwanted pregnancy (86.7%). Only

heterosexual men with occasional partners reported using condoms to prevent STDs (87.5%) (Izazola et al., 2000).

Sexual activity with other than the primary or regular partner is reported in a large number of people living with HIV around the world. In studies with gay men attending clinical facilities in the US, sexual encounters with non-primary partners are extremely high. In Seattle, Washington, 90% of HIV-positive respondents with a main partner reported casual sex with other partners during the two months preceding the interview. Although this is a very specific population, such findings suggest the potential risk of HIV transmission outside the main partner (Whittington et al., 2002). In this subpopulation, 30% of HIV-positive men (with and without main partners) reported having met their casual partners in bathhouses and 44% did not know the HIV status of their sexual partners.

In Mexico a household probability survey indicates that among respondents who had sex with men, around 3% of the sample, 27% reported anal sex with a casual partner with only 30% of these men using condoms for protection (Izazola et al., 2000). The survey did not focus on HIV-positive individuals or discordant couples, but it is one of the few studies that provide information for homosexual men.

3.3 Meanings of Sex

The previous section describes some sexual practices reported by HIV-discordant male couples; however, there is very little on MSM in Mexico, regardless of whether they are HIV-positive or live in a stable relationship. The evidence indicates that in spite of knowing the risk of HIV transmission to the uninfected partner, many of these men or couples still observe risky sexual practices. They report, for example, not using condoms consistently during anal intercourse and oral sex. They also report sexual encounters with non-stable or casual partners, suggesting the risk of HIV transmission to outside partners or re-infection within the couple. They also report a lower likelihood of condom use with a permanent partner than with a casual partner, which translates into higher rates of HIV transmission to the regular partner than to casual partners.

The most immediate question is why many of these couples do not use condoms in sexual intercourse if they know the actual risk of HIV transmission. The literature on the topic suggests that the meanings people attach to sex, especially those related to emotions, play an important role in HIV prevention. Rationalizations about sexual behavior and condom use are based not simply on information but on feelings and emotions as well. Emotions, for example, help to reorganize information received about sexuality and STD prevention and to construct the meanings attached to sex and condom use (Carrillo, 2002; Rhodes and Cusick, 2000; Rosenthal et al., 1998). The literature also suggests that meanings of sex need to be analyzed in the particular contexts in which participants are living.

Research has been primarily conducted among the general population, among subpopulations with a relatively small risk of HIV transmission, or with respondents who do not know the HIV status of their partners. Only a small number of studies have examined couples of mixed HIV status in which each member knows the high risk of transmission; even less is known for HIV-discordant male couples. This subpopulation deserves more attention because male homosexuals are one of the groups most affected by HIV/AIDS in many Western countries and because their social circumstances differ from heterosexual populations.

Due to the lack of research on HIV-discordant male couples or homosexual men in Mexico, the literature that will be reviewed below refers in many cases to MSM of other countries. This research has mostly been conducted in English-speaking countries and, in a few cases, in Brazil, Mexico, and Peru. The small sample sizes and the focus on specific subpopulations do not allow direct extrapolation to other subpopulations and certainly not to male HIV-discordant couples in Mexico. They are nevertheless important sources for the construction of the research questions; it will only help to trace out possible issues to investigate in HIV-discordant male couples in Mexico where there are no systematic studies.

a) As an Expression of Masculinity

In Latin America, and particularly in Mexico, there are very few empirical studies that directly explore the meanings of sex for homosexual men in the context of intimate relations: the sense they make from their intimate relations with their partner, the type of satisfactions that sex brings them besides physical pleasure, the situations created when they do not respond to their partners' desire for sexual contact.

Among research that exists in Mexico on sexuality, one group of studies focuses on sexual representations among heterosexually-identified men, generalizing their conclusions to all encounters between MSM. A central element in the representation of male sexuality in these studies is the concept of penetration as an expression of virility and domination. Men who are penetrated devalue themselves and enter into the category of homosexuals, while men who penetrate other men or women enhance their status and authority. Penetration contributes, in this way, to place men in different positions within the social space: masculine and insertive men have higher status than feminine and penetrated men (Amuchastegui, 2001; Rodriguez and Keijzer, 2002). Even in cultural contexts where there is not strong sense of homophobia, like among the raramuri indigenas of Chihuahua, heterosexual men who practice anal sex with men identified as homosexual, locally called reneke, osexuales or nawiki, reaffirm their sense of masculinity by playing an "active role" (Perez-Castro, 2001). These events occur during community festivities and after strong alcohol consumption, and it is a socially accepted behavior among some sectors of the raramuri population.

Similarly, other studies on particular homosexual populations in Mexico also report that penetration is a form of structuring relationships because insertive men retain social prestige associated with masculinity and receptive men lose such prestige (Almaguer, 1996; Carrier, 1995). Prieur, (1998 &1996), for example, arrives to such findings in her study of working class transvestites and their masculine partners, a particular group in which traditional gender roles are very powerful. Cordoba-Plaza (2003) reports that among masculine men who work as commercial sex workers, called mayates/chacales, in Xalapa, Veracruz, performing an insertive role symbolizes of not becoming vulnerable. Even if in practice these men also play a receptive role, they argue

they do it only if clients pay them more. Playing the receptive role simply for their own pleasure is perceived in these contexts as losing their masculinity and their status within a defined hierarchy of sexual practices, at least when viewed from a particular hierarchical scheme.

Although gendered models work well to help understand relationships between particular subpopulations of MSM, they cannot be used in all contexts. Studies suggest that traditional gender roles are not necessarily prevalent in homosexual men from other socioeconomic sectors and that penetration is not perceived as a form of placing men in different hierarchies. Prieur (1998) also indicates that among middle class homosexuals in Mexico gender roles may not be very important in defining sexual identities. Cruz-Sierra (2001) corroborates this idea. He finds that an important percentage of gay couples in Mexico City reports flexibility with regard to sexual roles. He indicates that the sexual practices of his participants do not correspond to their self-perceptions of their masculinity or femininity if there is one clear cut difference. His conclusions are based on a survey of 104 male gay couples, who are predominantly middle class, who have college and graduate education and are 33-years-old on average.

Focusing on penetration and its association to power is useful to understanding sexual interaction in some relations between MSM. But research also finds that not all homoerotic encounters include anal sex or are structured through gendered models: when only one man plays a masculine role and exclusively retains social power and prestige. Even in cases where penetration takes place and the participants accommodate to gender roles to some extent, the specific sexual practices they engage in do not always correspond to the gender that participants portray: contrary to what some research would expect, the effeminate participant very often penetrates his more masculine partner (Prieur, 1998; Gonzalez-Perez, 2003). In this sense specific sexual practices are not necessarily attached to any particular identity: active/passive roles are not monolithic. In his study on gay transvestite identity in Colima, Mexico Gonzalez-Perez (2003) concludes that identities are flexible and temporal as well as ascribed by the individual or

imposed by the collectivity. The latter usually are built on pre-conceptions that associate femininity with homosexual men, without leaving space for other forms of interaction[3].

Another critique is that the active/passive dichotomy is not always experienced as a power/disempowered relationship. In certain contexts MSM indistinctively play both of these sexual practices, depending on factors that go beyond the idea of power or privilege. Using such dichotomies uncritically to understand the dynamics between MSM is a way to reduce participants to their genitalia: the partner that penetrates is reduced to a penis by the theoretical model and the partner who plays a receptive role is reduced to an anus (Nuñez-Noriega, 2001). These theoretical models do not allow researchers to ask about other meanings that such sexual interactions have for men.

b) As an Expression of Emotional Intimacy

Only recently, in the context of HIV transmission, has research started paying attention to the reasons why people have sex and its importance in their lives (Carrillo, 2002). Although the findings do not exclusively refer to homosexual men, whether to individuals living with HIV or to HIV-discordant couples, they call attention to the meanings of sexuality and its relation to safe behavioral patterns. The main thesis of Carrillo (2002) is that sexuality is a way to express emotions and a validated method of "spiritual" communion with a partner. Even in anonymous or casual encounters, participants in the study fantasize about the idea of romantic love and the expression of trust and intimacy with the unknown partner. People report that even if the release of tension or physical pleasure is the ultimate goal of casual sex, they hope to end up in a relationship or they are hurt when there are no real possibilities for a romance.

Studies with couples of mixed HIV status in other countries also report that sex is perceived as a form of merging emotionally with the partner. Interruption of sex due to HIV-discordance so deeply disrupts the relationship that partners resume sexual activity, even if it is at the expense of HIV transmission (Van Den Straten et al., 1998; Sandstrom,

[3] Cantu (2002) also refers to the mutable and plural character of identity when he talks about the effect of migration and new household arrangements experienced by Mexican immigrants in the U.S. The social context provided by anonymity and relationships that supports gay life "transforms what immigrants think about themselves and their [specific] sexual identities'" (p. 389).

1996). In these studies, uninfected participants express feelings of rejection, and they push for the "normalization" of sexual activity in the relationship when they see the infected partner does not want to have sex anymore.

For many people sex is conceived of as a means of connecting so intimately that it allows someone to know a partner in a way no one else publicly could. Associated with this idea is a conception that trust and love will lead to mutual monogamy and that monogamy, in turn, will reinforce both trust and love (Sobo, 1995). Trust, love and mutual commitment are then central facts in deciding when to have sex and whether to use any kind of HIV prevention (Worth et al., 2002; Carrillo, 2002).

The intimate connection that sex can provide, according to studies in western Mexico (Carrillo, 2002), allows people to transcend a sense of isolation, helps them to relate to others and, to some extent, to connect to the world. This finding is similar to analysis of heterosexual and homosexual populations in the US in which sex is viewed as a social need and a part of being alive, an element that increases their self-esteem and their sense of worth (Daker-White and Donovan, 2002). Sexual contact with others is also defined as part of the human being's essence, part of being social entities who need to interact with others, and who judge and are judged on the basis of their physical attractiveness (Shultz and Van de Weil, 2003; Sandstrom, 1996).

All of these findings suggest that future research should analyze the relevance of emotional intimacy and romance as it relates to sex in different populations. There is a particular need to conduct this type of research with couples of mixed-HIV status because emotions may play an important role in contributing to the risk of HIV infection. As a corollary, all of this research suggests that it is important to analyze what emotional intimacy means for people and why it is so relevant in the context of sexual activity if we want to formulate more successful campaigns to facilitate HIV/AIDS prevention (Foreman, 2003).

3.4 The Meanings Attached to Lack of Condom Use

Extensive research on condom use has been conducted since the discovery of HIV/AIDS. A great part of this research has shown that in spite of information about transmission, people still practice sexual intercourse without any kind of protection. This is even true in the case of partners of HIV-positive individuals that know their high risk of being infected. In general, factors associated with a lack of condom use refer to the perception that condoms reduce physical pleasure, are unavailable, are unreliable to prevent STDs, and are associated with promiscuity.

In Mexico quantitative research focuses on questionnaires with closed or multiple- option questions that measure knowledge, attitudes, and practices. In these questionnaires respondents usually express their perceptions of condoms in terms of pleasure and reliability. Results indicate that high proportions of men think that condoms reduce physical pleasure or are not totally reliable (Izazola-Licea and Tolbert, 1993). This information, nevertheless, usually comes from samples where the great majority of respondents are heterosexual, making it necessary to do more research on homosexual population.

Studies using qualitative methodology indicate that migrant men, mostly heterosexual, perceive condoms as signs of distrust. Inability to speak about condoms with a partner occurs if the relationship is new. Men report needing time to be able to discuss safe sex. At the same time, once the relationship has lasted long and trust has developed, talking about condoms carries suspicions of infidelity and problems with the partner (McQuiston and Gordon, 2000).

Migrant men also indicate not using condoms because they are uncomfortable and because they have sexual relations with their wives or women they know who they suspect are not at risk of HIV. The criteria used to decide whether a woman is safe are if she looks healthy and if she is not promiscuous. Among migrant MSM who do not use condoms, respondents report loss of sensibility and partner's dislike: especially in the case of oral sex in which risks of HIV transmission are perceived to be very low. In addition, not using condoms is a sign of bravery and a sign of manhood, particularly

within a group of MSM who self-identify as heterosexual: suggesting the use of condoms implies the recognition of actively looking for sex with other men that jeopardizes a heterosexual self-identity (Bronfman and Minello, 1995).

Explicit research with homosexual and bisexual men (Juarez City, Mexico) also shows negative attitudes toward condoms (57% of respondents), who express that the feeling is not the same or that the size is a problem. Men also report not using condoms due to personal and partner's dislikes, drunkenness when having sex, or unavailability of condoms (Ramirez et al., 1994). Due to the quantitative nature of the methodology, this study does not explore in more detail different reasons for disliking condoms or the factors behind negative attitudes towards condoms. The study also does not focus on HIV-discordant couples.

In the following sections, detailed research on different reasons for not using condoms in MSM is reported. Due to the lack of information about Mexico, most of the findings refer to English-speaking countries. As mentioned before, these findings are useful because they help to identify important issues that deserve attention in Mexico**.**

a) Unprotected Sex as a Marker of Stability

The literature about English-speaking countries suggests that trust and intimacy reduce the chances of condom use in gay male couples. To what degree this is different or similar to the heterosexual population is a question that deserves attention. Some researchers hypothesize that because in many western countries HIV/AIDS has affected male homosexuals more time than any other population, trust and intimacy have less impact on the sexual behavior of well-informed gay men (Pilkington and Kern, 1994). Rhodes and Cusick (2002), for example, find that among HIV-discordant couples, homosexual couples were more willing to use condoms than heterosexual couples. Their results need, nevertheless, replication in other contexts before the generalization of such findings to populations with different cultural values and social norms.

Other studies suggest opposite findings. Homosexual male couples do not use condoms because "raw sex" is a sign of stability and commitment in the relationship, or, at least, expresses the intention of mutual monogamy. In addition, researchers interpret

the absence of condom use as an idealized form to assure intimacy (Worth et al., 2002). Requesting condom use by a partner during sexual intercourse is symbolized as a sign of distrust and infidelity, and, for some particular subpopulations, such requests raise issues of past sexual experiences (El-Basel et al., 2000; Galligan and Terry, 1993). Even if monogamy is not actually practiced, not using condoms in the contexts of intimate relations is an idealized proof of fidelity and commitment to each other (Worth et al, 2002).

Expectations of mutual commitment and fidelity develop with the duration of a relationship. In HIV-discordant male couples this development affects the concern of infection over time. When relationships begin, people are more concerned about protecting themselves from infection, but as duration and quality of the relationship develops, fears of viral infection drop and condom use is less frequent (Rhodes and Cusick, 2000; Remien et al., 1995).

Over time, people change their priorities between, on the one hand, having protected sex and keeping a certain emotional distance from their partner, and, on the other hand, having unprotected sex and achieving a deeper emotional closeness that the lack of condom use implies. When the risk of infection and uncertainties with regard to life are high, choosing unprotected sex may be viewed as protecting the long-term relationship and the intimacy that it provides (Rhodes and Cusick, 2000; Boulton et al., 1995; Worth 2002; Remien et al., 1995). In this context, having sex without condoms shows the love someone has for a partner. Following this logic, some studies report that young gay men use condoms less frequently with a main partner compared to casual partners because it is around main partners that they more commonly construct the idea of romance and commitment (Choi et al., 2002; Moreau-Gruet et al., 2001: Gold et al., 1994).

It seems that along with the search for love and intimacy discourses of public safety interweave in people's minds. Condoms represent the possibility of protection from an STD but also reduce the possibility of increasing emotional bonds. For public health professionals the first scenario is more important and the answer is clear: using

condoms is the best option; but for people interacting in sexual encounters and intimate relationships, the answer is hesitant and in some cases not using condoms may be more comfortable from an emotional point of view (Rosenthal et al., 1998; Blechner, 2002). Public health messages associate condoms with casual sex and lack of love which creates a sense of mistrust; people involved in emotional relationships generally operate under a different logic: trust leads to love, love leads to sex, and sex to more love and trust. Condoms are therefore not seen as necessary since they condoms are perceived as impersonal and diverging from the idea of love and intimacy (Carrillo, 2002).

A recent upsurge in unprotected anal intercourse among gay men in the US may reflect the perceived high risk of losing pleasure and intimacy brought by using condoms. Fears of getting HIV and other diseases may be present, but respondents express that life is a constant balance between competing risks. Decisions must be made depending on the perspective that each person has not only with regard to health but also to friendship and romance (Blechner, 2002; Gold et al., 1994). This leads to the hypothesis that emotions, romance, and intimacy play an important role in condom use and that such dimensions in personal life do not change by merely providing scientific information.

b) Unprotected Sex and the Re-establishment of an Undesired Imbalance

The notification of HIV status in discordant couples brings a series of issues related to the past sexual practices of the infected partner. In some cases couples break up or experience serious adjustments in the relationship, especially if the infection of one partner was due to casual sex. In this case, the uninfected individuals report not being able to trust their partners and having great feelings of betrayal. They also express pressure to provide emotional support for their partners and to deny any fears of infection through sexual intercourse. Nevertheless, there are some other couples who remain together and even become closer as a consequence of the HIV status of one member. In this situation, uninfected respondents express their wish to have unprotected sex as a form of commitment and emotional support for the HIV-positive partner. They place high value upon spending time together and decide to take the risk of sexual intercourse

without condoms (Beckerman et al., 2000). This second group of couples deserves attention as they are at great risk of HIV transmission or re-infection.

For many HIV-discordant couples, the presence of the infection in only one partner brings an undesired imbalance in the relationship and a loss of intimacy, which can only be recuperated through the infection of the other partner. Getting infected is perceived as a commitment to the HIV partner, and decisions are taken to make the HIV infection a joint experience: to make life spans similar between the partners and to eliminate the roles of cared for and caregiver (Palmer and Bor, 2001). In some cases, the uninfected partner has sex with casual partners hoping to get infected with HIV. Being infected from a casual partner rather than from the primary partner is a strategy used by the uninfected person to eliminate any possible feelings of blame and guilt that his infection could cause in the HIV-positive partner (Palmer and Bor, 2001).

The imbalance brought by HIV in discordant couples is also observed in the lack of libido in only one partner due to the effect of medicine, advanced stages of the disease or psychological effects in the HIV-positive partner, which in the eyes of many discordant partners is interpreted as a rejection of the HIV partner, rather than an effect of the disease. This again is related to issues of intimacy and closeness within the couple (Palmer and Bor, 2001; Sandstrom, 1996).

What all this shows is that emotions are important in the sexual lives of individuals and that deeper knowledge of this issue is needed to create more effective campaigns against HIV transmission. It is important to understand how emotions are related to the perceptions that people have about condoms and how they affect the decision to practice safe versus unsafe sex in different cultural contexts.

3.5 Conclusions of Literature Review

Research in English-speaking countries indicates that male couples of mixed-HIV status do not use condoms consistently in spite of knowing the risk of infection to the HIV negative partner and re-infection in the case of the HIV positive partner (Remien et al., 1995). In Mexico, research with individual gay men, as opposed to couples, reports

lack of condom use (Izazola et al., 2000; Ramirez et al., 1994). In these studies, men are not aware of their sexual partner's HIV status, and the studies occur on particular sub-populations: men who attend STD clinics or who are not involved in a stable relationship at the time of the interview. Only one study analyzes the dynamics of gay couples in Mexico City, and it does not provide information about the HIV status of respondents or whether they are aware of their partners' HIV status (Cruz-Sierra, 2001). This study reported lack of condom use in a high proportion of couples due to beliefs in monogamy and fidelity. Paradoxically, a high proportion of couples reported having casual sex in the last six months many of them without using condoms, with the consequent risk of contracting an STD and passing it to their partner. Due to the lack of research on HIV-discordant couples in Mexico, studies on this population are needed to see the extent to which the findings in other countries are replicated or rejected by couples aware of the negative health consequences of unprotected sex and presumably with knowledge about the disease and its modes of prevention.

A question that derives from previous information is what makes men aware of their discordance to put their mutual health at risk during sexual intercourse? A small number of studies in English-speaking countries with gay men suggest that meanings that people attach to sex play an important role in the specific practices they engage in (Rhodes Cusick, 2000; Remien et al., 1998). The construction of such meanings derives from everyday interaction and the re-creation of shared values about sex and practices linked to identities. In that process information about the disease as well as emotions attached to sexual practices are central elements.

In this respect, there is a debate in Mexico about the extent that particular models of understanding men's sexuality are really appropriated by men with different social backgrounds and sexual preferences, as well as to what extent they are linked to risky practices. Theoretical models that explained heterosexual male's sexuality through the idea of penetration as an exercise of virility and power also report a lack of condom use as an example of bravery and manhood (Diaz, 1998). The problem with such models is that they work in certain contexts, but they cannot be extrapolated to all men or to all MSM. When used uncritically to explain relations between MSM, the

patriarchal/phallocentric model also adopts a gendered dichotomy of the roles that each member of the couple plays within the couple (Almaguer, 1996; Carrier, 1995). Such theoretical models are simplistic when we try to understand all MSM because not all relations are permeated by gendered roles and penetration is not present in all homoerotic encounters (Nuñez-Noriega, 2001). Consequently, research about risk factors for HIV transmission should go beyond masculine/feminine binaries rigidly attached to power/disempowered categories.

Recent critiques indicate that even if differentiated gender identities and penetration are present within a couple, the sexual roles do not correspond necessarily with the gender identity or are not linked with power differentials. In their fieldwork, researchers have found that feminine men usually penetrate masculine men and they do not perceive themselves as having more or less power due to such practices (Prieur, 1998). In fact, penetrated men may get some sense of empowerment when proving their seductive capacity. These critiques lead to abandoning preconceived ideas about the dynamics at the interior of gay couples explaining them exclusively through gender roles.

Other research in English-speaking countries report that the reasons for not wearing condoms among stable gay couples have strong emotional elements: mutual trust and love leads partners to develop the idea of monogamy which makes condoms unpleasant and a sign of promiscuity. In this way, unprotected sex becomes a sign of stability and commitment and an idealized form of assuring intimacy, which increases as the duration of the relationship does. These ideas were reinforced in the past through public health messages that associated condoms with casual sex and promiscuity (Worth et al., 2002; Remien et al., 1995; Rhodes and Cusick, 1994).

From these studies it has been hypothesized that men in HIV-discordant couples face a challenge because of at least two different types of risks: on the one hand, men need to evaluate the risk of infection or re-infections if they do not wear condoms; on the other hand, men need to evaluate whether and how they feel about losing intimacy and mutual connection by reducing their health risk when wearing condoms (Blechner, 2002; Gold et al, 1994). The decision seems to be difficult as emotional factors are present when well-informed men need to make a decision. In the present dissertation I analyze

this hypothesis to see the similar or different patterns that Mexican MSM can take based on their understandings of sexuality, protection, and relationship.

The literature suggests that the meanings people give to sex and condoms play an important role. In particular, emotions and feelings in the contexts of stable relationships influence the risk-taking behavior of many HIV discordant couples. Emotions help to reorganize in people's minds the information received about sexuality and STD prevention and to shape the meanings attached to sexual activity and condoms.

The research reviewed here highlights the need to explore the role of emotions in greater detail as they relate to sexuality. It indicates the importance of knowing what intimacy and other emotions mean for MSM in contexts of stable partnerships in Mexico. By looking at these questions, it will be possible to understand how men prioritize different risks when living in same-sex couples of mixed HIV sero-status, that is to say, how to weigh the risk of HIV transmission versus the risks of losing intimacy and romance.

The literature also indicates that meanings of sex and condom use and the role of emotions in shaping such meanings are not uniform for everybody. Sexual identities and cultural contexts associated with them may also affect decisions with regard to how and when to have sex. Perceiving sexual penetration and taking risks as symbols of virility may lead some men to unprotected sexual intercourse whether they define themselves as heterosexual or homosexual men. Having a particular sexual identity, whether heterosexual or homosexual or any corresponding variant, may also lead some men to perceive themselves as more or less vulnerable to HIV infection. But things get even more complicated when to this axis of analysis we add people's conceptions of love/relationship/sex and disease, which will be the focus of this dissertation.

Chapter 4: Data and Methods

4.1 Selection Procedure

This study draws on forty-four in-depth interviews with MSM involved with an HIV-discordant partner (nineteen HIV negative and twenty-five HIV positive). Thirty two of these interviews correspond to sixteen couples where both members accepted the interview. In the remaining cases only one member of a discordant couple was interviewed. This last group of interviews includes men who are currently involved in an HIV-discordant relationship (eight interviews) and men who were involved in such a relationship in the past (four interviews): one as HIV-positive (and who had broken up with his partner one month before the interview), and three as HIV-negative men. Of these three men, one remains HIV-negative and the other two became HIV-positive through sex with a man other than their partner (in one case the original partner to which he refers his discordance had already died). For purposes of the analysis these two men are added to the group of uninfected men, making a total of twenty-one HIV-negative men and twenty-three HIV-positive men. In all cases, the idea is to explore the experience of persons aware of their discordance of HIV and of their risk of infection and/or re-infection.

The original idea was exclusively to interview men in currently discordant couples. Two factors changed that criterion: 1) the difficulty of identifying male couples aware of their HIV-discordance, 2) the difficulty to obtain interviews from both members of the couple. These two factors led me to include men who in the past were part of a couple that was aware of their HIV status and capture their experience with their discordant partner. I did not find fundamental differences for the purpose of this dissertation in the experience of men in current HIV-discordant relationships compared with those who were no longer in such a relationship. Their responses were different, nevertheless, in that their narration was filled with a certain degree of reflection on a relationship that had already occurred. Such reflection was not present in men's narratives of current couples, especially when they had little time of knowing about their discordance. Such difference should not be considered a problem for the study, but rather

as an element that helps us to understand the dynamics of intimacy within the couples and their interactions.

During my field work I found three men who were not currently living in Mexico City. I incorporated them in the study, because they had lived in Mexico City before in two cases and because one was a partner of one of these. These men were living in cities 70 kilometers and 110 kilometers away from Mexico City, from which people commute every day or week to work or to visit family members. The men interviewed did not portray the characteristics of natives or locals from a close community of the State where they live. On the contrary, they had a lot of in common with people from Mexico City. One of them was born and raised in Mexico City and had family in that city. He moved to a place where many locals from Mexico City have houses to get away from the crowds and pollution during weekends or when retired (Cuernavaca). He still had a lot of ties in Mexico City and traveled on a weekly basis to sell his work and to visit his family and friends. Another interviewee was originally born and raised in the State of Veracruz, but he moved to Mexico City to do graduate studies. His life story was not different from other interviewees who were born in different states and moved to Mexico City while adolescents or young adults and had established permanent residence there since then.

4.2 Recruitment and fieldwork

Of a total of seventy-five men identified as being part of an HIV-discordant couple, I was able to interview forty-four. Of the remaining thirty-one men that I was unable to interview, only five said up front they were not interested; the other twenty-six men answered affirmatively to my request for an interview, but it was difficult actually to carry out the interview: some did not show up to the interview; others postponed the interview several times due to work or medical problems. After several phone calls it was difficult to reach them again. It was difficult to know how much they were really interested in the study or whether they were too shy to say no to my study, but I always tried to persist in getting an interview without violating their own will.

The first stage of fieldwork started in January 2004 when I conducted five pilot interviews with men in HIV-discordant male couples at Comunidad Unidad en Respuesta al SIDA (CURAS, A.C.). This organization enthusiastically received my project and provided different facilities to carry out the pilot interviews, and, latter on, the actual interviews: office space and initial contact with patients with HIV. During the pilot interviews I only interviewed one member of each couple: two interviews corresponding to HIV-negative men and three to HIV-positive men. During this stage of the fieldwork I was able to check the length of the interview as well as the pertinence of different questions. The second stage of fieldwork started in August 2004 and ended in August 2005. During this stage I contacted over thirty HIV/AIDS organizations and physicians and I presented them a brief summary of my study and the IRB approval from the University of Texas.

The organizations that I visited were all different in nature (private= three, public= thirteen, and non-profit= fifteen). In official institutions and some large NGOs my project had to go through an internal process of ethical approval that lasted from one to five months. The larger the organization, the more requirements I had to submit for approval and the longer I had to wait for an answer. In some cases the rules were not clear and were constantly changing, raising doubts that the institution would actually facilitate the research. In one case, my submission was lost after I made modifications or clarified the doubts of their internal committee. By then I had almost completed the current number of interviews with patients from other institutions, so I simply notified them of my intention to stop their process of approval.

The initial approval of my study was easier with smaller organizations. In these the project did not have to go through a long process of revision. I simply submitted a letter of invitation and the IRB approval that summarizes the objectives of the study. The same process was followed when I talked directly with physicians of HIV patients from private or public clinics or when I talked to different support groups of HIV-positive persons. In all places I left several letters of invitation to the study, so these could be distributed among patients with a discordant partner. Then I called on a frequent basis to see if there was a person with the inclusion criteria interested in participating in the study.

After my project was approved by an institution or a physician, the following step was to identify the patients that had a discordant partner. This process took some time because there were no records of which patients had a partner or what the status of the partner was. Physicians had to start asking their patients about this information, patients who usually go to the clinic for medical check-ups every three or six months. Only a few physicians remembered patients with the characteristics required for my study. In all cases, physicians talked first to the patients and gave them a letter with my contact information and the general purpose of the study. Sometimes the patients called me directly from their house or office or physicians called me when the patients were in the clinic so I could make the basic arrangements for a meeting to explain the interview and the study to them in more detail. In other cases, physicians asked patients' permission so that I could call them. It was not uncommon that the explanation of the study could not be done in detail through the telephone because patients did not live by themselves or were at work so they could not openly ask questions about the study. When this was the case, I had a preliminary face-to-face meeting with my potential interviewees to explain in more detail the objectives of the study. In the preliminary meeting they had more opportunities to inquire about the study and to think about whether or not to participate. I noticed that it was easier to gain their trust to accept participating in the study if they knew me in person. If they agreed we set up time and date to carry out the interviews separately with each member. Sometimes it was possible to interview only one partner due to health problems or the work schedule of the second member (even if both had agreed to participate in the beginning). Some other times, only one member decided to participate.

To facilitate the process of recruitment I also contacted the facilitators of support groups and asked permission to explain my project. Participants in these support groups are men (mostly MSM) and women with HIV that on a frequent basis meet in a space provided by clinics, hospitals and NGOs, but that make decisions on their own with regard to the means of operation and the permanence of the group. At these meetings, people usually talk about coping with the disease and the problems they face in institutional and non-institutional settings. In some cases I visited these places only once and in some others I went on a frequent basis, depending on the number of people

attending the group and whether I had gone on a day where everybody or very few had attended the meeting. Most of the time, I received enthusiastic interest from people at the support groups; even women and heterosexual men asked about the possibility of participating. Nevertheless, the large majority of MSM indicated that they did not have a partner at the moment of the study. At these support groups I also left several letters of invitation with my contact information so these could be distributed among friends not attending the groups or who joined the group in the near future. I also contacted the leader of the support group several times on the phone to see if a new member fit the profile and was interested in the study.

4.3 Data Collection

Each interview lasted between one and a half and two hours. With the exception of two interviews, the rest were tape-recorded with the permission of the respondent and transcribed afterwards. For the two interviews that were not tape-recorded due to informants' decision, I took notes during the interview and wrote a final draft afterwards to avoid forgetting events. Of these two interviews that were not tape-recorded one corresponds to each different HIV group; they are not part of the same couple.

Participants decided on the location and time of interview: their house (if they lived alone or only with their partner), a private office that NGOs gave me for that purpose (CURAS, A.C. and a non-profitable Hospital), and my house (only one interview). The interviews were conducted and transcribed by me. The interviews included a short section to collect basic socio-demographic information about respondents. The interviews also had semi-structured open questions that encouraged participants to talk about their intimate relationships and motives for having sex, whether they use some form of prevention against STDs-HIV infection or re-infection (including condom use), and reasons for not using protection if they didn't do so. In addition, respondents were asked about the processes of coming out as gay men and with regard to HIV-discordance, what they thought of their sexual identities, and their interaction with their families.

Throughout the process of fieldwork new topics appeared that were not originally considered in the guide interview. One of these topics was men's perceptions of bodily fluids, especially perceptions about semen. To identify these new topics it was useful to have the last section of the interview that solicited informants' reactions to the questions asked. This exercise helped to introduce new questions in subsequent interviews that were relevant to understanding many risky situations.

4.4 IRB Approval and Ethical Issues

Prior to the interviews, respondents received an Informed Consent Letter with the seal of the University's IRB. I explained the project to the respondents, and they were allowed to ask questions before, during and after the interview. They were informed about the voluntary and confidential nature of their participation.

4.5 Data Analysis

To analyze the interviews, I built several matrices by group of respondents: HIV-positive men and HIV-negative ones. The rows represent each different interviewee and the columns each different topic. In the corresponding cell where rows and columns converge there is a quotation of what an interviewee said with regard to that specific topic. The starting point in designing the matrices was using the topics of the interview guide and identifying new ones by reading all the interviews. These matrices allowed me to have a big picture of what had been said about a particular topic, making it possible to identify the characteristics of the informants and comparing their answers. To avoid losing the meaning of the context in which certain statements were made, I consistently went back to the original interview. I also went back to the interviews to scan for information that was not common to all informants but that was relevant for those having practices of risky sex.

After the information was organized in the matrices it was possible to write the story of how the men got infected with HIV and disclosed this information to their

partner, whether diagnosis affected the sexual practices of both members, the different situations of risk where condoms are not used, the meanings attached to sex and to different parts of intimate life, and the challenges of being in an HIV-discordant relationship. In most cases, responses did not vary by HIV status of informants. When responses varied, different sections within each chapter were created for HIV-positive men and HIV-negative men separately. To present the results I avoid using respondent's real names. Instead I created a list of pseudonyms that I assigned randomly to each participant. See tables at the end of the dissertation to know the characteristics of informants and the pseudonyms assigned to them.

4.6 Generalizability of Results

Respondents interviewed in this study correspond to MSM of different backgrounds in terms of age, education and occupation. In this sense, the analysis does not correspond to a single and homogeneous group, but on the contrary captures a broad range of experiences. Nevertheless, the generalization of results to a larger group of MSM or to the general population cannot be made due to the small number of respondents and the particular situation of being HIV discordant. In addition, the characteristics of the sample in terms of age and education differ considerably from those of the male population in Distrito Federal (DF): the proportion of men by age groups in the sample show the shape of a normal curve (with a concentration of men in middle age groups: 30-34 and 35-39), while the proportion of men in the DF concentrate in the first age group (20-24) to decrease slowly with each subsequent age group (INEGI, 2005). In terms of education, men in the sample are doing far better than the general male population in DF: the greater proportion of men in the sample have completed College or graduate studies (around 50%), while only 28% of adult men in DF have completed at least one year of that level of education (INEGI, 2005).

The analysis presented here generally portrays the opinions and experiences of HIV-discordant MSM. The richness of the study derives from the detail with which certain topics can be explored and the discovery of elements that place these men at risk

of HIV transmission or re-infection (even after being aware of the presence of HIV in one of them).

It most be taken into account that the majority of these men (especially if aware of their discordance long ago), have regularly attended different clinical settings, support groups, and in some cases, are activists with NGOs. Such activity leads them to posses a lot of information about the disease, the effects of medications, the possible effects of not using prevention for both men (those infected and those not infected), and so on. In this sense this group may be different from other MSM who are not aware of their discordance or who may not have access to a series of social networks or institutions that facilitate living with HIV, and that help to change the group's outlook upon it from a lethal to a chronic disease. It may differ also from other MSM that regardless of their sero-status do not have a stable partner; or from heterosexual couples, where relationship dynamics are different compared to male couples.

With respect to HIV-discordant couples that denied the interview, it is difficult to assess how similar or different they are from those interviewed. No detailed information was able to be collected from them for purposes of comparison. Using only general information given by the physicians (age, occupation and time in the relationship) I can say that men or couples that did not participate are equally heterogeneous as the men interviewed. They include men from different ages, with different occupations, and who are in long- as well as short-term relationships.

4.7 Validity and Reliability

a) Veracity

The validity of the information collected on sexuality through in-depth interviews depends on various factors. One of them is the honesty with which interviewees report their sexual practices. Apparently this is a major issue because it is difficult to expect that people will easily talk about sexuality with a stranger. But it should also be taken into account that there are similar problems with other kinds of information. People do not always accurately report their age, income, marital status, and the like on surveys or

questionnaires (Mari Bhat, 1990; Waver, 2000; Pedace and Bates, 2000). In all cases, researchers have to rely on what informants actually report. Consented upon in-depth interviews is one of the most important formats for obtaining information about informant's sex life.

To reduce the problem of respondents' hiding information and to achieve a most accurate description of their sexual life, I tried to develop a good rapport with my interviewees. In some cases a first light of trust was achieved by the recommendation that physicians or their friends made of my study. A second and more important moment to build rapport with interviewees occurred when I was explaining the project and the informed consent letter. In all cases, I tried to provide a free environment during the interview in which they could talk about anything about their sexual lives without receiving any kind of disapproval or having a third person present. I made very clear that I was not expecting a specific answer to my questions, so any answer they gave me was valid. My only purpose was to understand the reasons underlying different types of behavior, whether such behavior implied risk of the spread of HIV or not, and to capture the voices of people with HIV and their partners (a task that usually is left aside in favor of physicians' or experts' opinion). I also told them that they should not see me as an expert in sexuality or as superior to their experiences. When they asked me, I told them that my HIV status was negative and that my sexual orientation was gay. Knowing my sexual orientation may have facilitated respondents to feel comfortable talking about sexuality, although I did not necessarily find differences in responses between those who knew it and those who did not. In addition, the level of respondents' elaboration did not systematically vary between HIV-negative and HIV-positive men.

I stressed the fact that nobody else would have access to the information they provided me: neither physicians, nor organizations that referred them to me, nor their partners. I also mentioned that their names would not appear in any part of my dissertation or anywhere else.

Certain elements make me believe that I was able to achieve good rapport with my interviewees. Many of them told me at the end of the interview that they felt comfortable talking about sexuality with me, and they encouraged their partner or friends

in HIV-discordant couples to participate. Some respondents also called me after the interview to tell me things that during the interview they did not remember but that could be of some help for the study. Other people mentioned that for them it was uncommon and sometimes embarrassing to talk about very particular aspects of their sexuality, but they made an effort to be honest because they think that something beneficial for HIV discordant couples could emerge out of the study.

I can also judge the rapport built by the tone that the interviews took. I showed my true genuine concern for the study and I tried not to be rigid or cold with interviewees. In general, participants made jokes, talked in double entendres, and laughed about particular situations. Many of them also were willing to provide deep detail about particular sexual events or their relationships with family, friends, and so on. Others even gave me their consent in case I wanted to use their real names. They had already talked in several forums about their particular experience as men with HIV or were pretty open about their sexual lives. Others indicated they wanted to keep confidentiality about their HIV status, but still went into detail about their sexual lives.

b) Memory Problems

There are some other problems that could affect the quality of data. These are the unintentional omission of certain information due to memory problems or lack of time during the interview. These are also problems that surveys or interviews about any topic currently face. For my study, I tried to facilitate the memory of certain events by detailed follow-up questions after a general question. This allowed, for example, me to capture risky situations that participants had not taken into account in the general questions because they did not remember them or even because they did not perceive them as risky. With such follow-up questions I was able to detect practices reported as sporadic, but that because of the risk of HIV transmission they convey, can potentially become a source of new infections or re-infection in the population studied. Because some of the respondents also practice sex outside the couple they could expand the transmission to other sectors of the population.

c) Reliability

This dissertation is based on a theoretical framework that examines the sexual experiences of MSM as fluid processes that are contextualized, relational and situational. For this reason such experiences are open to changing contexts and conditions (Gonzalez-Lopez, 2005; Connell 1995). For instance, many informants reported changes in their perceptions about unprotected sex, illness and relationships after they became personally involved with HIV-positive friends or after interacting with physicians.

Chapter 5: Characteristics of Respondents

5.1 Introduction

This chapter describes the basic characteristics of respondents. It provides information about their age, education, occupational status and time at which they became aware of their discordance. For HIV-positive men, it also provides the last CD4 cell counts and viral loads to get an idea of the stage of their diseases' progression. For both partners, it also provides information on their sexual identity and the social contexts in which they are out with regard to their sexual preference, as identity is a fundamental element shaping the creation of meanings and social interaction. Finally, in the case of HIV-positive men, it describes people and places where they have disclosed their HIV status. This information will help the reader to situate the informants of the study and to frame the results of the following chapters.

5.2 Socio-demographic Characteristics

Of a total of forty-four men interviewed, nineteen were HIV-negative at the moment of the interview and twenty-five were HIV-positive. Out of the twenty-five HIV-positive men, two were HIV-negative when they had a discordant partner in the past. With these two men the interview focused on the time they were in that discordant relationship so they are grouped with the HIV-negative men. For this reason, a total of twenty-three HIV-positive and twenty-one HIV-negative men are counted for the analysis.

Out of the twenty-three HIV-positive men, twenty-two currently had a partner: fifteen of these were also interviewed. In one case the respondent chose the ex-partner whom he was for nine years, rather than the current partner whom he was for one year for the interview. Out of nineteen HIV-negative men, seventeen currently have a partner, and out of the two HIV-positive men who were grouped with the HIV-negative respondents for purposes of analysis, only one currently has a partner who is HIV-

positive. This information means that for fifteen current couples and one ex-couple, both partners were interviewed for a total of thirty-two individuals. In the remaining twelve couples, only one member accepted the interview (five HIV-negative men and seven HIV-positive men).

Table 1: Does Respondent Currently Have a Partner?

Do you currently have a partner	HIV- (*)	Partner Interviewed	Ex-Partner Interviewed	HIV+	Partner Interviewed	Ex-partner Interviewed
Yes	**18**	**15**	**0**	**22**	**15**	**1 (***)**
No	**3 (**)**	**0**	**1**	**1**	**0**	**0**
Total	**21**			**23**		

Notes:
*** Two HIV + men are included in this category because they provided information about the time they were HIV- (or did not know their status) and were living with an HIV + man. In one case the partner died due to AIDS; in the other case, the respondent is still living with his HIV-positive partner.**

**** In two cases the partner died. One of these respondents had a second HIV+ partner whose relationship broke up after a couple of years. In the third case, the relationship also broke up after nine years.**

***** One respondent currently has a partner (one year long). Nevertheless, he decided to call his ex-partner who he was with for nine for the interview.**

The distribution of respondents by age shows that HIV-negative informants are on average younger by four years than HIV-positive informants: thirty-three and thirty-seven years of age respectively. The following table shows that HIV-negative men distribute evenly in each age group starting at younger ages (twenty to twenty-four years than HIV-positive men, while this second group of men concentrate more after age thirty.

Table 2: Age Group by HIV Status of Respondents

Age Group	HIV-	HIV+
20-24	4	0
25-29	4	2
30-34	4	7
35-39	4	6
40-44	4	4
45-49	0	4
50 +	1	0
Total	21	23

The distribution of respondents by education shows a slight advantage for HIV-positive men. In both groups most men have a college degree or more, followed by men with a high school degree, and then by men with a junior high education or less. Nevertheless, there is a greater concentration of HIV-positive men with a college or graduate education and with a secondary education compared to HIV-negative men. On the other hand, the concentration of HIV-positive men in the lowest category of education (high school or less) is lower compared to HIV-negative men.

Table 3: Education by HIV Status of Respondents

	HIV -	%	HIV +	%
Complete JHS/less	6	28.6	3	13.0
Complete SHS & Tech Education	5	23.8	7	30.4
College and Graduate Studies	10	47.6	13	56.5
Total	21	100.0	23	100.0

The distribution of respondents by occupation shows that the larger proportion of informants work in the category of professionals regardless of HIV status: physicians, engineers, accountants, university professors and artists, among other occupations (over 30% of HIV-negative and positive men). The second major occupation for HIV-negative men is clerks or office employees (19%), followed by owners of small businesses, technicians, students and unemployed men (9.5% in each case). In contrast, the second major occupation for HIV-positive men is in technical work (17.4%), followed by clerks and retired men (13.0% in each case). The existence of retired men among HIV-positive informants only is in large part due to the illness. These men were pensioned at a moment in which they got deeply sick and could not work. After initiating antiretroviral treatment, these men improved their health by reaching undetectable viral loads in two cases or low loads in one case). They now freelance in different activities as a way to support their income and to reincorporate themselves into productive life.

Table 4: Occupation by HIV Status of Respondents

	HIV-	%	HIV +	%
Merchants	1	4.8	1	4.3
Employees/clerks	4	19.0	3	13.0
Directors/Managers	1	4.8	0	0
Owners of Small Business	2	9.5	2	8.7
Professionals	7	33.3	8	34.8
Technicians Associate Profs.	2	9.5	4	17.4
Students	2	9.5	0	0
Unemployed	2	9.5	2	8.7
Retired	0	0.0	3	13.0
Total	21	100.0	23	100.0

On average, the number of years men have been in their current relationship is six with a range between four months and twenty-two years. More than half of these men, regardless of HIV status, report being in the relationship for five years or more; approximately 20% have been together between one and five years. An important percentage has been together less than one year: 29% of HIV-negative men and 22% of HIV-positive men.

Table 5: Time Engaged With the Partner

	HIV-	**%**	**HIV+**	**%**	**Couples**	**Individuals whose partner was not interviewed**
					According to HIV-	(HIV-) (HIV+)
5 to 11 months	6	28.6	5	21.7	5	(1-) (0)
1 & 2 years	2	9.5	3	13.0	2	(0) (1+)
3 & 4 years	2	9.5	2	8.7	1	(2-) (1+)
5 & 7 years	5	23.8	5	21.7	4	(0) (1+)
8 & 9 years	2	9.5	5	21.7	2	(0) (3+)
10 & more years	4	19.0	3	13.0	2	(2-) (1+)
Total	21	100	23	100	16	12

The average number of years during which men have known their discordance is three with a range between five months and eight years. The following table shows that larger proportions of men interviewed have become aware of their HIV discordance just recently: around 33% of HIV-negative men and 30% of HIV-positive men became aware of their discordance no more than eleven months prior to the interview. As the number of years in the relationship increases the proportion of men aware of discordance decreases, with the smallest proportions having eight years or more of knowledge of their discordance: less than 10% in both groups.

Table 6: Time Respondents Are Aware of HIV Discordance

	HIV-	**%**	**HIV+**	**%**	**Couples**	**Individuals whose partner was not interviewed**
					According to HIV-	(HIV-) (HIV+)
5 to 11 months	7	33.3	7	30.4	6	(1-) (1+)
1 & 2 years	4	19.0	6	26.1	4	(0) (3+)
3 & 4 years	6	28.6	6	26.1	3	(3-) (2+)
5 & 7 years	2	9.5	2	8.7	2	(0) (0)
8 & 9 years	2	9.5	2	8.7	1	(1-) (1+)
10 & more years	0	0.0	0	0.0	0	(0) (0)
Total	21	100.0	23	100.0	16	12

More than half of the men interviewed, regardless of their HIV status, met their partner when diagnosis had already occurred: 57%. Of these, around half of the HIV-positive men disclosed their HIV status within the first two weeks of the relationship. The percentage of men who disclosed their status or was informed between one and six months corresponds to 38.5% for HIV-positive men and 47.7% for HIV-negative men. Only a small percentage of men disclosed their status or was informed by their partners after six months of relationship: 8 % in both cases.

Out of the total number of men interviewed, 40%were already in the relationship when one of them was diagnosed with HIV. More than half of these men, regardless of

sero-status, had been engaged in a relationship for more than one year and up to twenty years when that occurred (56% of HIV-negative men and 70 % of HIV-positive men). It is interesting that in a large percentage of cases diagnosis occurred within the first month of the relationship: 22% of HIV-negative men report their partner was diagnosed with HIV before one month of relationship, while 20% of HIV-positive men were diagnosed in that period of time.

Table 7: Time Elapsed From Diagnosis to Disclosure of HIV to Partner.

	HIV-	**HIV+**	**Couples**	**Individuals whose partner was not interviewed**
			According to HIV-	**(HIV-) (HIV+)**
Couple met when HIV+ partner was already diagnosed	**Subtotal=12**	**Subtotal=13**	**Subtotal=9**	**Subtotal=7**
Immediate disclosure of HIV: less than 2 weeks	6 (50.0%)	7 (53.8%)	4	(2-) (3+)
From 1 to 6 months	5 (47.7%)	5 (38.5%)	4	(1-) (1+)
More than 6 months	1 (8.3%)	1 (7.7%)	1	
Couple met when HIV+ partner was not diagnosed yet	**Subtotal=9**	**Subtotal=10**	**Subtotal=7**	**Subtotal=5**
Diagnosed 1 month after	2 (22.2%)	2 (20.0%)	2	
Between 1 and 6 months				
From 7 months to 1 year	2 (22.2%)	1 (10.0%)	2	
More than 1 yr (up to 20 yrs)	5 (55.5%)	7 (70.0%)	3	(2-) (3+)
Total	**21**	**23**	**16**	**12**

The average number of years that HIV-positive men have been diagnosed with HIV is six years with a range between five months and eighteen years. The largest proportion of men was diagnosed more than five years ago: close to 50%, followed by

those diagnosed between one and five years ago (38.1 %). A smaller percentage of men was diagnosed in the year prior to the interview: 14.3%.

Table 8: Time Since Diagnosis with HIV (Only for HIV+ respondents)

Time Elapsed between diagnosis and Interview	HIV+	%
Less 1 year ago	3	14.3
1 & 5 years ago	8	38.1
More than 5 years ago (up to 18)	10	47.6
Total	21	100.0

In general, all men with HIV were in good health at the time of the interview. Many of their immune systems had been seriously affected right before the diagnosis. In fact, their diminished health at that time led them to get tested for HIV. In many cases, when they received positive results, the numbers of CD4 cells that protect the body against infections were extremely low and the viral load very high. Nevertheless, with the use of antiretroviral treatment, CD4 cell counts increased and the viral load decreased substantially. At the moment of the interview the combination of these two indicators showed that informants' health was, if not at its highest point for all of them, at least good. The following table indicates an important proportion of men with less that 400 CD4 cells. Measured alone, this indicator could suggest that an important proportion of men had less than what it is considered as good health in medical spheres. Nevertheless, all of these men presented low viral loads, an indication of slow disease progression, and in some cases, these levels were even undetectable: less than fifty copies. When checking case by case, men with less than 400 CD4 were mostly under 3,500 viral copies with five of them undetectable. Only one man had 20,000 viral copies and another had 14,000 in their last visit to the physician. These numbers, although not very small, are still in the middle range of viral loads and are far from the marker to initiate antiretroviral treatment: 50,000 copies.

Table 9: Latest CD4 Cell Counts (Only for HIV+ Respondents) *

CD4	HIV +	%
100 to 200	2	8.7
200 to 300	3	13.0
300 to 400	5	26.1
400 and more	7	34.8
Don't Know/NR	4	17.4
Total	23	100.0

***Note: 400 & more is considered healthy, less than 200 is worrisome.**

Table 10: Viral Load Counts (Only for HIV + Respondents) *

Viral Count	HIV+	%
Don't Know/NR	5	21.7
Undetected	10	52.2
51-400	2	8.7
401-3,500	2	8.7
…		
14, 000-20,000	2	8.7
Total	23	100.0

***Note: the presence of fifty copies of the virus or fewer is considered ¨undetectable¨; the presence of more than 55,000 copies is considered the minimum level to start medical treatment. Notice that the relatively low number of viral copies in most respondents is due to the medical treatment already initiated.**

5.3 Sexual Identity of Respondents

As part of the subjective reality, identity is the result of dialectical social processes: it is created, maintained and reshaped through social interaction. At the same time, identity affects and reshapes the social structure of which it is a result (Berger and Luckmann, 1967, p. 173). The relevance of this concept for the present research is that identity affects the creation of meanings that individuals give to certain events and actions in historical and physical contexts. Identity also has specific consequences on their course of action. For example, literature shows that heterosexual identity of MSM

due to homophobia and stigmatization facilitates lack of condom use due to such men's fears of being mistaken as actively looking for sex with other men if they carry condoms with them. This phenomenon in turn increases the risk of STD's transmission.

For this reason, the present section explores how respondents define themselves in terms of their sexuality. It will show that with very few exceptions, all men interviewed defined themselves as gay or homosexual. Regardless of the difference in which they openly share their sexual preference with family or friends, these men do not self-portray a heterosexual identity. By living in an affective and erotic relationship with other men, informants have developed an identity different than the heterosexual identity.

In the present research, identity is also related to the awareness of HIV in one member of the couple. This circumstance will affect the interaction at the interior of the relationship: having a particular HIV status in these couples will imply certain negotiations and attitudes to maintain their relationship. At the same time, certain sets of social conditions will lead or deter some couples to share their HIV discordance to broader social networks, and the feedback received will ease the challenges they face as couples or make them more difficult. This process in turn will also create conditions for the interaction of each member at the interior of the couple: for example, when family or friends of respondents are not aware of the HIV status of one of the partners, one or both experience greater situations of stress and anxiety due to the lack of social support during a health crisis. This difficulty is also mediated by the kind of interaction that participants have with each partner's social network, whether a relationship of cooperation or cold distance.

With the exception of two men who identify as bisexual, the rest of respondents referred to themselves as gay or homosexual. In some cases, they used these two terms interchangeably, and in other cases they preferred the term gay, considering it nicer or having a connotation of affection. In two cases, the men interviewed preferred not to use any term to refer to their sexuality because they did not like to be labeled or classified in any kind of category. They considered such labeling unnecessary and a cause of conflict and discrimination. These men did not hide their desire for men but they were simply against what they called "rigid" forms of classifying people.

Among respondents who identify as gay men, many report having had sexual relations with women during adolescence, and, in some cases, they subsequently got married and had children. They report their sexual relations with women as part of their sexual experimentation, following the mainstream patterns that they perceived they were expected to follow, or that they simply liked women at the time. Back then, some respondents had occasional relations with men as what they considered a form of exchanging favors or out of curiosity. At the time they did not consider themselves gay or homosexual. On the contrary, they report having girlfriends and being emotionally involved with them. Some men were making plans to get married. With time they discovered that they could also get emotionally involved with men, and they stopped thinking of their previous sexual contacts with men as uniquely motivated by gift exchange or experimentation. Initially, this circumstance led these men to confront themselves with the original perception they had about their sexuality. Many informants report that when they accepted their sexual desire for men and their deeper emotional involvement with them, they were able to maintain a long term relationships as in the case of the actor from Veracruz who first worked as a stripper when he arrived in Mexico City where he met his current partner.

Other men reported being aware of their sexual preference since early childhood. In their earliest memories they were attracted to other men. They report knowing that they felt different since childhood, and as they grew up they confirmed their sexual and emotional interest in men. When they became adolescents or young adults, many of these men shared their sexual preference with some members of their family. Sisters and mothers were usually the first relatives to know and sometimes the only ones. The initial reaction of the family was to send respondents to a psychologist, a process that would take several months and which usually ended up in a respondent's total acceptance of his sexual orientation, a result contrary to what the family expected. Surprised by the respondent's decision, many family members would first show distance and rejection, but over time they would have a more accepting attitude. In many cases, respondents would not openly talk about their sexual preference with all members of the family, specifically with their fathers or brothers. With these male relatives there was usually less interaction

than with their sisters. Respondents report, nevertheless, that many supportive comments from their brothers made them think that they were aware of the respondents' sexual preference.

In very few situations, a member of the family, usually a mother, realized the respondent's homosexuality before respondents discovered it. In these situations the mother was totally open to her son's sexuality and told him that any decision he made about it was appropriate. These respondents, nevertheless, had not totally realized their desire for men or had a girlfriend or felt desire for women. Others had problems accepting their sexual orientation and denied it to their mothers. They had not had any sexual contact with other men or had not been socialized to feel comfortable about homosexuality. The idea of being gay or homosexual was still far away from their thoughts, and they perceived of it as unacceptable. While in primary school, they had been the object of ridicule, and they associated homosexuality with discrimination. As they grew up and related with other homosexual men, they discovered their sexual interest in men and assumed their sexual orientation, usually after they had their first long-term partner.

5.4 Disclosing Sexual Preference

At the moment of the interview approximately 1/4 of the respondents had not openly talked about their sexual orientation with everybody in their family. Some of these men had only talked with a sister or with another brother (also gay), but they did not talk openly about it with the rest of the family. They report that the whole family, nevertheless, might know of their sexual orientation due to the many years they had lived with their boyfriend or partner. These respondents perceived that their family was very conservative and would be disappointed if the respondents openly expressed their sexual orientation. They considered that their mothers and fathers were too old and belong to a different generation, in some cases having strong ties to the Catholic Church, and that there is no need to give them a hard time by making them deal with such a situation. Parents do not ask and they do not tell. But there are reasons to believe that parents

already know, as when respondents and partners visit their families and sleep in same bedroom or when parents visit them and see them sleeping in the same bedroom.

The remaining three quarters of respondents indicate that their family openly knows their sexual orientation. Among the HIV-positive men, an important number reports coming out when they became HIV-positive. Some of them had already talked to a sister long before being diagnosed with HIV, but they had not been openly gay with the rest of their family. For years respondents and the sisters had kept the situation to themselves, but after respondents became deeply sick, they talked to other members of the family about their sexual orientation. In other cases, respondents talked to their family for the first time about their sexual orientation right after they were diagnosed with HIV (case of a man whose nurse informed his aunt about his HIV status. Later, while in the hospital, he explained to his mother the reason he had HIV). Although in most cases the family showed surprise and shock about the sexual orientation and HIV status of respondents, they now show certain solidarity with respondents. Their families do not totally accept the sexual lives of the respondents, but they have come into a situation in which they now can tolerate it.

Many other HIV-positive men, as well as a greater proportion of HIV-negative men, had talked with their families about their sexual preference long ago. The circumstances varied. Some of them were caught in a telephone conversation or kissing their boyfriends, and some others talked directly about their sexuality with their families or the mother realized her son's homosexuality before the respondent himself did. The degrees of the families' initial reactions also varied, but in general most families learned to be tolerant about the respondent's sexuality while they may not talk openly about it.

Among men who have disclosed their sexual orientation to their family, a small group report that the initial strong opposition that their family showed only decreased a little throughout time. In many of these cases there was an initial violent reaction, especially from their fathers who always expressed their unhappiness about the respondents' behavior. In this respect respondents indicate that while little boys they were always repressed for not doing what other boys did. They express that when adolescents they were subject to violence when telling their parents about a sexual

incident with another man. These men said that their parents always mentioned that the last thing they wanted was to have a ¨faggot son,¨ and they grew up with fears of their own sexuality. For many of these men, assuming their sexual orientation and living their lives as gay men represented severing relationships with many members of their families, in particular with their fathers.

5.5 Disclosing HIV status to other people

a) Only my Partner and other HIV-Positive Men

Some HIV-positive men have shared their sero-positivity only with their partners (seven out of twenty three men). They have not talked to any member of their family because they do not want to cause them any stress. These men feel that it is unnecessary to worry their families when they are still in good health. They plan to inform their family about their HIV condition once their immune system has deteriorated or they start having health problems. Among these respondents there are some men who are not out with their family in terms of their sexual preference. So talking about their HIV status is complicated. These men rely on their partners, maybe some friends, and perhaps support groups to cope with their emotional crises or health problems. And when problems arise at the interior of the relationship, these HIV-positive men have to cope basically by themselves with the disease. Besides other HIV-positive people that they may have met in support groups, these men have nobody else to share their health condition.

Partners of these men also report the pressures and hazards of being the main, and perhaps unique support of HIV-positive men. Rarely do the HIV-negative respondents comment to their own acquaintances about the HIV status of their partner. It has been decided in mutual agreement within the couple not to divulge the partner's HIV status. Due to this lack of an extended social network that is aware of their HIV discordance, these couples have problems coping with the health problems of the HIV-positive partners or with releasing tensions created by their different situation in the relationships. Even in cases in which HIV negative informants have told a close friend or family member, usually a sister, about their partner's sero-status, there has not always been total

understanding that could result in practical or tangible support. In these situations, partners of HIV-positive men do not find somebody really willing to listen to their particular problems and to be of some help. Comments on quitting the relationship may lead to more stress or doubt about their relationships than to affirmative actions that benefit the couples.

In this sense, HIV-negative men report willingness to help their partners as much as possible, but at the same time, they feel an enormous burden due to their own personal work. They also express their worries about the future, if their partner becomes seriously sick. In these cases it would be difficult for the HIV-negative partner to properly attend his partner and keep working to pay the bills at the same time. They report that if this situation arose, they would like the help of some friends or their partners' families.

b) Some members of my family

Other HIV-positive men (nine out of twenty three) indicate that besides their partners, few members of their family know about their HIV status. These men have most of the time lived with the virus without major symptoms, and only after a time when they became symptomatic they disclosed their HIV status to one member of their family. In many cases they did so because of a recommendation by their physician or as a way to reduce the level of stress for their partners. In case of an emergency, they wanted to have someone in the family who could help their partner and knew what to do. In many cases the first person they talked to was a sister. Later they communicated their sero-positive to the rest of their siblings. In many cases, they agreed with their siblings not to tell their mothers about their HIV condition for as long as possible. Most of them report that their mothers usually worry too much about their children, and respondents do not want to cause them a lot of suffering. They report having seen how some mothers have not recovered after losing their sons due to AIDS. There is also the perception that respondents will live without visible symptoms during many years, and that perhaps they will live longer than their own mothers, due to the advanced ages of these. So these respondents indicate that there is no rush to communicate with their mothers about something that could be emotionally devastating.

Other respondents (seven out of twenty three) have told everybody in their families about their sero-status, including their mothers or fathers, the father being usually the last person to know or the person for whom respondents show the least concern. In all these cases, mothers as well as other family members have shown concern and interest in the respondents' health, but their specific support has depended on the acceptance of the respondents' sexual orientation. In situations in which the relationship has been one of distance, the specific support has not been more than asking about respondents' health, with a certain amount of resignation from the family for whom ¨everything is lost¨. In situations in which the relationship between the respondent and family has been closer and there is a more open attitude towards the respondent's sexual orientation, the support from the family has been more tangible: caring for respondents when needed and open discussion of their health problems

Partners of HIV-positive men, who shared their status with a wide social network, experience comparatively less anxiety and difficulties with coping with the virus than men whose partner has not disclosed their HIV status with nobody else. Nevertheless the degree to which the couple accommodates to their HIV discordance will depend on the real support offered by the family, as well as on how well the partner and the HIV-positive's family get along. In cases in which there is certain distance between HIV-positive men and their families, the support consists in asking about their health and wishing them good health, but the family does not go beyond that kind of attention. In this situation the couple still has to solve the particular problems that emerge due to the presence of HIV by themselves.

When the partner does not get along with HIV-positive men's families, he can still feel isolated in terms of assistance to their partners' particular needs. In this case the family can offer its support to the HIV-positive member, but the problems between HIV-negative men and their partners' families can dilute the effectiveness of family support. In addition, HIV-negative men still find no form where they can share or express their own particular vision of their relationship to anyone, leading to their own frustration.

5.6 Conclusions

Socio-demographic data from informants indicate that HIV-positive men in this study tended to be slightly older than HIV-negative men (thirty-seven vs. thirty-three years of age), more educated (56% vs. 48% with a college degree or more), and occupy professional and technical positions in the labor market (52 vs. 43 %). The average number of years that men reported being in a relationship was six, with more than half of men being in a relationship for five or more years.

Of all respondents 57% reported having met their partner after the HIV diagnosis had already occurred. Approximately one half of these men reported their status or were informed of such status during the first two weeks of the relationship, and only a small percentage of HIV-positive men (8%) informed of their sero-status after six months of relationship. According to their CD4 cell counts and viral loads, basically all HIV-positive men were in good health conditions at the moment of the interview.

In terms of sexual orientation, most men (forty out of forty-four used the terms gay or homosexual to refer to their sexual orientation. Only two men identified as bisexual and another two preferred not to be labeled in any category because they consider it stigmatizing. None of the men interviewed denied their physical and affective desire for men. The identity portrayed is important because in spite of different levels of stigmatization in their immediate social networks (family and friends), they did not conceal their sexual and affective relationships with men. Being in a long-term relationship or having that expectation showed the interest of these men in developing emotional ties with their partners, as well as the creation of a style of living in which interaction with other gay friends or attending social events or gay places was to a greater or lesser extend present. Such interaction reinforced their identity as gay or homosexual men, even if many of them reported to be selective about the places where they would openly express their sexual orientation.

Identifying themselves as HIV-discordant couples and having contact with AIDS organizations, support groups and medical personnel, also allowed them to recognize their risks of HIV infection and re-infection and to be conscious about the need to wear

condoms. This in turn led many men to wear protection during sexual intercourse, but, as will be seen later, it did not occurred in all couples or all the time. Their discordance regarding HIV status also led to difficult situations in the relationship due to the fears of infecting or being infected with the virus or to secondary re-infection. HIV-negative men also were stressed due to the need to provide adequate care to their partner, a situation that was aggravated when family or friends did no know about the HIV status of the partner or were reluctant to provide support.

Chapter 6: Becoming Aware of HIV-Discordance

6.1 Introduction

This chapter deals with the set of expectations and meanings that HIV-positive respondents had for not wearing condoms when they got infected, as well as with the expectations from HIV-negative respondents about their relationships. The premise of the chapter is the same as the dissertation's: that meanings attached to events/things have consequences for the behavior of individuals and that such meanings are recreated from a common set of shared meanings through everyday interaction. Based on the story of HIV-positive men, this chapter describes the process of diagnosis and the implications for their lives. It also compiles the sexual practices they had at the moment of infection and how these may have determined their infection. Presenting different scenarios where respondents did not wear condoms also helps us understand some of the reasons why men engaged in risky situations (within a previous stable or casual relationship).

This chapter also presents the reaction of HIV-negative men to their partners' sero-positivity and the factors that led them to continue the relationship in spite of having strong fears of infection or having even a mere few days of knowing about them. The courses of action depart from absolute rationality which would dictate that minimizing the risk of transmission should be a priority. Under a purely medically rational logic it would be difficult to understand why people that barely know potential partners decide to stay together, in spite of the risks of infection. The answer lies in the particular expectations and meanings they attach to relationships and sexuality which are not contemplated by medical-rational models.

6.2 HIV-Positive Men

a) Initial Diagnosis

The purpose of this section is to introduce the reader to the way respondents started dealing with HIV in their lives. It presents three different scenarios in which HIV-

positive respondents discovered they were infected: when they were very sick with the corresponding need for a test for HIV; when they were mildly sick and they were confident that their problem was not related to HIV; and when they were perfectly healthy and they were simply tested as a routine practice. Although this section is merely contextual and it refers to past relationships, reasons for not wearing condoms start to show up. Through respondents' narratives it is possible to link particular perceptions of condoms, intimacy, and friendship to practices of unprotected sex.

a.1) HIV Test when Deeply Sick

Eight out of twenty-three men were diagnosed with HIV when they became very sick. In some cases, respondents reported that they were close to death. Due to their compromised health, they had to be hospitalized, and after being tested for HIV, they received positive results. At the moment of hospitalization their immune systems were so fragile that they had very small numbers of CD4 cells and huge viral loads in their bodies. After therapies and treatment with antiretrovirals their health improved, increasing their CD4 cells (in some cases to normal levels) and substantially decreasing their viral loads, sometimes to undetectable levels.

Ignacio, forty, exemplifies this situation. He was tested HIV-positive in the hospital while he was in a coma. After the third day of being in the hospital, he woke up and physicians informed him that he had been tested for HIV and the results were positive. Although he had not been tested before (or at least in a long time), he had the presentiment of being HIV-positive. Years before the incident in the hospital, the man who at the time was his partner received a call telling him that an ex-boyfriend had died due to Pneumonia. The respondent associated that information with AIDS. During the three years that they were together they never used condoms, and his partner got sick of what he called a weird disease at some point in their relationship. The respondent reports that this was the only period of time in his life that he had unprotected sex due to his profound love for this man. After they broke up, the respondent got herpes and started thinking about the possibility of being HIV-positive. Two or three years later, he started losing weight and having several health problems: diarrhea, dermatitis psoriasis, and so

on. He suspected that everything was due to HIV, so he started wishing to have a rapid death and to avoid prolonged suffering. He drank heavily day and night. His family thought that he was loosing weight due to his drinking. One time when he caught the flu and candidiasis he did not look for medical attention, until he fell in bed and started having a fever. After many doctors visited his house, he was taken to the hospital almost in a coma. Then he confirmed his suspicion of being HIV-positive (over ten years ago). He then started taking antiretrovirals (during the last six years), and he currently has over 300 CD4 cells. During the last two or three years his viral load has been undetectable.

a.2) HIV Test due to Small Health Problems

In other situations, positive men discovered their HIV status due to small health problems (ten out of twenty-three). Their health status was generally good, but a minor problem made physicians suggest getting an Elisa test. In most of these cases, respondents were confident that the results would be negative. They were surprised when they discovered that their results were positive. After initiating antiretroviral treatment they also reduced their number of viruses' copies in their bodies, and they were able to maintain their health. In this respect, Marcos, thirty-three, says that after one year of not wearing condoms with his partner he presented some problems in his penis:. He went to the clinic and the physician told him that he had syphilis. Although he does not know how he got it, he says that it could have been from his previous partner with whom he never used condoms during the five years that the relationship lasted. He could also have contracted the STD during unprotected casual sex that he had with two or three men after he finished that relationship. One year had already past since he started a relationship of nine years when he went to the physician due to an infection in the genital area. After being diagnosed with syphilis and receiving treatment for the symptoms along with his partner, the physician asked him to be tested for HIV. He showed no fears because he had always been faithful. Nevertheless, he started being suspicious when the results were not ready on time and were postponed until fifteen days later, when the physician finally told him he was HIV positive. His partner was tested too. As his partner's results were negative they could not understand how the respondent's test could be positive. The

respondent got tested again in a second clinic and the results were positive again. He reports that in his two previous relationships he never used condoms because he thought that if they wore condoms, his partners would be unfaithful. At the moment of the interview, his two previous partners had already died. In the first case it was confirmed that the cause was due to AIDS, and in the second case the respondent believes it was due to the same reason. The respondent was diagnosed ten years ago, and he has been under antiretroviral therapy for a long time.

a.3) Testing For HIV as a Routine

Some other men had no symptoms at all of any disease at the moment of their diagnosis, and their health seemed to be in perfect condition (three out of twenty-three). They were tested just as a routine practice, and they were also confident that they had nothing to worry about, but when their results were unexpectedly positive, these men were resistant to believing the results, so they went to different clinics to have other examinations, hoping there was a mistake in the results. Gerardo, thirty-three, reports, for example, that he usually used condoms. Only a very few times did he not use condoms with people whom he already knew and trusted. A few months after he met his current partner, who was HIV-negative, he went to get tested upon a request from his partner. His partner was HIV-negative, but having had two previous boyfriends with HIV, the respondent's partner was afraid that the results of the test were not accurate and that he could infect the respondent. To avoid any potential responsibility about this he wanted to know the respondent's HIV status. The respondent went to a private clinic to get the test and the results were positive. He reported being surprised because he practically always used protection. He says that he never had problems using condoms. It was only with a few friends that he knew for a long time that he did not wear condoms. After the respondent was diagnosed as HIV-positive, he told one of these friends about the positive results, and one year later his friend also received positive results to the Elisa, suggesting that maybe on that occasion the respondent got infected. (He has been taking antiretrovirals for four years, and he is now undetectable. He was diagnosed HIV-positive five years ago)

b) How Did I Get Infected?

This section describes different scenarios of infection as HIV-positive respondents recall them. It shows that particular meanings about sexuality, condoms, and illness led respondents to engage in unprotected sex. Sometimes unprotected sex is reported as the common practice back in the time when they got infected (thirteen out of twenty-three), other times the practice occurred only a few times or under very specific circumstances (ten out of twenty-three). After asking respondents about their reasons for not wearing condoms in the past, some themes became evident as factors of risk: perceiving AIDS as a distant threat or even more as an invention of the mass media to stop homosexuality led men not to perceive themselves at risk of infection; knowing a person for a long time made respondents believe there was no need for protection; similarly, associating condoms with sexual promiscuity and decreasing intimacy prevented respondents from wearing condoms; and low self-esteem and feeling the obligation to please others, even in the context of casual sex, led men not to ask for protected sex due to fears of making the partner uncomfortable.

b.1) HIV as an Invention to Stop Homosexuality

HIV-positive men varied in their answers with regard to their frequency of condom use in the past, before they received a positive diagnosis of HIV. In some situations respondents did not use condoms at all because they did not feel at risk of becoming infected (ten out of twenty-three). These men did not have a lot of information about the virus or they saw it as something distant that occurred in other countries, but not in their local communities or among the people they met. If somebody suggested the use of condoms it was all right with them, but if they did not have condoms or their partner did not want to use them, it was fine with them too. In fact, sometimes they preferred not to use condoms because not doing so enhanced their pleasure.

Raul, forty-eight, represents the point of view of many men of his generation. When mass media started talking about AIDS, he believed it was merely an invention to stop homosexuals from gaining rights in society. He reports not wearing condoms back then because he did not feel at risk, and when he was living with his second partner he

was diagnosed with HIV fourteen years ago. He says that in the 1980s people did not have the culture of wearing condoms yet, and consequently, he had never used them before, not even with his first partner with whom he was engaged for five years.

The second year of his second relationship his partner started losing weight and having high fevers. They visited naturist physicians, but the treatments did not work, and his partner's health worsened. Later on his partner was diagnosed in advanced stages of AIDS and died at the end of the 1980s. The respondent postponed a couple of years the test for HIV due to fears of confirming what he was already suspecting. It was only when he had health problems that he decided to visit the physician and received positive results of HIV.

b.2) Trust in Long Term Friendship

Other men report condom use regularly in their past (ten out of twenty-three). They nevertheless report not having used condoms in very particular situations or with very specific people. In some cases they would not use condoms in a one night stand with a friend or somebody they already knew (two out of twenty-three). They report that just knowing the person made them trust that nothing would happen that particular time. After all, the person they were having sex with was not a stranger. That person was somebody that respondents perceived as within the same social group: similar education, common friends, social status, and so on. These respondents had information about the virus and were conscious to some extent to protect themselves from risky situations. Nevertheless, in a moment in which they did not have a condom or their friend suggested not to use it, they did not feel at risk and accepted having sex without protection. It was years later, when respondents were diagnosed with HIV, that they also were informed that the person they had sex without condoms was also HIV-positive, or in some cases, had died due to AIDS. For example, Oscar forty-one years old and seven years ago diagnosed as HIV-positive, recounts the moment that he thinks he got infected with HIV:

> *It is very clear . . . [I even know] the moment in which it happened. As I told you before [. . .] my greatest sexual desire was to be in contact with bodily fluids [. . .] Then I finished my relationship of thirteen years where I had been able to have exchange [of sexual fluids] without any problem [*

. . .] That was over, and I went back to the moment [. . .] of spying, in which you see, but you are not having a plain sexual relationship. Then in this case there were activities in darkrooms with touching, kissing, and a little bit of oral sex [. . .] but always with a lot of fears [. . .] very uncomfortable, even more with the use of condoms. Since I was adolescent, seventeen or eighteen years old, I had a friend for whom I felt a lot of attraction [. . .] and he also felt attracted to me, but as I was in this other relationship that lasted thirteen years, I never had the opportunity to have something with him. There were no infidelities or anything like that. I never liked to be unfaithful and even less to be disloyal. [After I broke up with my previous partner] I ran into him when I was working [. . .]. It was eight months before I met my current partner. We walked together in the restaurant and [. . .] "hey, I want to do it with you, because I think that you are a person that takes precautions and that has been conscious [about HIV] [. . .] with education, like me. You are not having risks" [. . .] all of which he gave me affirmative answers and said "Yes, of course." So we arranged the perfect meeting, in a hotel, after my work [. . .] and [then] there was exchange of bodily fluids. That was the only exchange of fluids that I had in five years. At the beginning of my current relationship I got tested [for HIV] and then I see that I have the problem. Then I am breaking my head to know where [it] could have been [that I was infected], in what moment [. . .] and maybe through oral sex [. . .] here, there but no [it was impossible] [. . .] because there was never an intake of bodily fluids, not even pre-seminal fluids. Immediately when I felt the flavor I spit it out. There was a lot of saliva in my mouth [. . .] [And I was] like a dentist checking my mouth with a magnifying glass before I decided to do something [. . .]So I did not know where I was infected. And a common friend with my ex- partner one day calls me and says: "hey, this person has just died [. . .] from a cancer in the kidneys [. . .] well to tell the truth he was HIV-positive [. . .]and during his last year of life he developed AIDS and he had like twenty-five different health problems, the last one was cancer in his kidneys." At that moment I discovered what person (had infected me) without any doubt.

b.3) Perception of Condoms as Facilitating Promiscuity

Men that got infected with HIV from a previous stable relationship report that in any other relationship they would have always used condoms, but it was with a particular stable partner that they did not use them for the whole period of the relationship (six out of twenty-three). In these cases, respondents indicate that they thought it unnecessary to take any kind of preventative measure because after all, they were in a stable relationship. They were having sex with one partner only and they perceived not wearing condoms as

normal. For many, condoms were synonymous with cheating, and the simple idea of bringing the topic to conversation was a reason for distrust and problems in the relationship. Respondents were diagnosed with HIV years after breaking up, and then they would discover that their former partner with whom they practiced unprotected sex had infected them. Whether such previous partners knew about their own HIV status is something respondents did not know.

b.4) Low self-esteem and Expectation of Romance

When describing how he could have been infected, Enrique, thirty-one, indicates that it was through casual sex. He says that it was probably ten years ago because he rarely used condoms. One time he even caught Hepatitis B. When asked about the reasons for not wearing condoms, this man mentions that he had low self-esteem. Back then most of his relationships were short term, and some of them just lasted a couple of hours. Even in those cases, he imagined that perhaps with time he would get to know his new partner so there was no need for protection. In addition, he was not used to bringing condoms with him and did not feel at risk of anything. He says, "I felt young [. . .] I felt strong, and at the moment I felt that nothing was going to happen." Now that he is HIV-positive, he thinks about how things could have been different back then. About that he says, "[I wish I had been] more secure of what I wanted, to be sure that I was going to get involved with a person, but having control of the situation [. . .] Protecting myself."

Another man, Mario, reports that he probably became HIV-positive through casual sex in the United States. He reports that he always used condoms because he was very concerned about being infected. Very few times did he not use condoms because he or the man he was with did not have any. He remembers one time he met a man in a bar and they were both drunk. They went to the respondent's place and neither of them had condoms. The respondent reports not being confident about stopping sex. They were already in his apartment, and he thought it was rude not to do what they had gone there to do. It was as if he now had to please this man he had just met because he had come all the way to the respondent's place. The respondent says that he did not have a particular reason for not using condoms, like liking raw sex or getting more excited. It was simply

his low confidence to say "no," to think about others before his own needs or safety. When asked about how he got infected, this man says,

> *I have two hypotheses. I have thought a lot about where I was infected, because I was very careful. According to me I was [. . .] always very careful. When I was living in the US I heard a lot about the topic [HIV/AIDS]. So I always tried to be cautious [. . .] being careful with whom I was going to have something [. . .] I believe it was weaknesses [. . .] I have had a lot of moments of weaknesses in my life. I had a lot of problems with low self-esteem before [. . .] so I have the impression that it was during a casual encounter [that I was infected] [. . .] And it was absolutely without condoms for not being able to say "no" [. . .] For saying, "well we are already here [. . .] or if I tell him "no," he is going to get mad. That was the cost [. . .] and it is affecting me even now. And that is one of the hypotheses [. . .] and the other hypothesis is that it was something that I don't remember: that is to say, it could have been eight people with whom I could have sex [. . .] but I do not know. But I believe that the most reliable [hypothesis] is with this guy that I told you about [first hypothesis].*

Talking more about the first hypothesis, this man adds,

> *I believe everything was a question of low self-esteem because [. . .] if I say "no," he is going to get mad and then "how it is possible that he gets mad, right?" I did not think of me as I tended to think first of other people [. . .] Now I can say "no." [. . .] And if now I lived the same experience again, I would say "no." But back then, I do not know [. . .] that moment of weakness [. . .]if we already left the bar, if he already came to the house, if we are already naked and we are doing it [. . .] and if I say "no" even if we do not have condoms [. . .] what do I do? He is going to beat me. [Now] I would prefer that he had beaten me and right now I would not be infected [. . .] but not being able to say "no" just to avoid him getting mad [. . .] or I already did all the show and now how [. . .] It was in that moment in which I felt weak, because I even ceded in two aspects: because I did not like to be penetrated, for example. I even had to accept the penetration. Then I suffered on two sides: on the moral side and the physical side. I believe it was with him [that I was infected] [. . .] after [a] long time has passed I still remember. I accept my responsibility,*

6.3 HIV-Negative Men

a) Initial Reaction before Revelation of Partner's HIV Status

This section and the following go back to the premise that people's perceptions about things have a great impact on their actions. Such perceptions emerge from people's interpretation of events in which knowledge and emotions play important roles in conjunction with cultural and social factors. In the present section, two broad reactions emerge from the interviews. Such reactions are associated with the moment in which respondents became aware of their partners' HIV status: when respondents discovered their partners' sero-positivity shortly after they engaged in the relationship, whether the same day or during the first months, the respondents stressed that their partners' confession of their HIV status was a sign of trust and reliability. When HIV discordance emerged after many years of living together, respondents report feelings of betrayal and anger, in combination with the need to show support to their partners. Some of these factors will also be present in the next section, including reasons to continue in the relationship. In all cases fears of infection and shock were also present.

In the first group different scenarios of reaction were reported. Respondents that were informed the same day or within the same week (six out of twenty-one) decided to continue the relationship because they thought the person they had just met was worth it and had all the characteristics they were looking for in a partner. The fact that their partners openly declared their HIV status was judged as a sign of their reliability and trustworthiness. Some of these respondents were already acquainted with information about HIV and its modes of prevention, and decided to take an "open minded attitude." They thought that with caution and by avoiding risky sexual practices there was not much to fear. In this sense, Mario describes how his current partner disclosed being HIV-positive shortly after they had met, and when Mario did not know his own HIV status. Since his partner disclosed being HIV-positive they have been living together for eight years. Mario was diagnosed HIV positive the second year of the relationship:

> *When we were talking on the bus [on the way to my house to have coffee], he [suddenly] told me: I am HIV-positive. I thought "we had met just two hours ago and he told me he was HIV positive." In the beginning I was*

afraid, but I was cautious, like when you are just getting to know somebody. I had met people [before] with HIV but I was not sexually attracted to them. And this was the first time that I felt sexually attracted to someone with HIV. Maybe I had already been in bed with someone with HIV but I did not know it. So my attitude was [to have an] open mind: "nothing will happen. We will use protection and that's it." And we always used protection and he was very careful since the beginning. That is something that I really liked about him: he was very cautions and careful. [So that night] that I am telling you about, he came to have coffee [at my house] [. . .] since then he has stayed and he never left. He keeps having coffee ever since eight years ago [laughs].

In the group of respondents whose partner became HIV-positive after many years in the relationship (nine out of twenty-one), the presence of an acute infection or disease was the cause for visits to the physician. The partners and respondents were tested for HIV within different intervals of time or at the same time. After an initial period of disbelief, the partner is tested for HIV several times until he accepts the fact that he is HIV-positive. Respondents also get tested several times and are disconcerted for showing no sign of the virus, until they also understand that based on the test, they are HIV-negative.

After confirming the difference in HIV status, some respondents report feelings of anger and betrayal toward their partner. They report that their relationships suffered a process of deterioration. Other respondents indicate that they felt compelled to show strength and support for their partners, even when they were also confused and afraid. They indicated that they were not worrying about HIV but were concerned about their partners' well-being. For them the information about their partners' HIV status confronts them with their fears of infection, but after reflection, they realized that their love for their partner was more profound than they had thought. For this reason they decided to continue the relationship.

b) Reasons for Continuing in the Relationship

This question was posed to those who were aware of HIV discordance shortly after engagement in the relationship or even prior to it (twelve out of twenty-one). It explores the expectations that men had about their new relationships and discerns the

reasons for a behavior that from certain rational points of view could seem contrary to zero reduction of risk of infection. It goes back to the idea that people attach meanings to things based on an interpretative process and on the creation and re-creation of shared meanings. The conjunction of these processes has consequences on their actions. The results presented here are examples of respondent's creation and re-creation of shared meanings of love, romance, and sexuality, sometimes learned and reinforced through the mass media. Throughout respondents' narratives, it is possible to identify main factors involved in engaging in a relationship with an evident risk of HIV infection: emotional stability provided by a relationship had positive consequences from the point of view of respondents upon their own self-esteem; the honesty and integrity of the HIV-positive partner were stronger than respondent's fears of infection; and an association between risk of infection and pleasure. The presence of these factors was not mutually exclusive, and same individuals reported many of these in different degrees.

The question was not directly posed to respondents in long-term relationships, as in these cases, it was evident that the presence of affectionate ties resulted from living together for a long time although their reactions are included as part of the following chapters.

c) Emotional Stability Provided by a Partner

In some cases respondents stressed the emotional stability that having a partner represents (five out of twenty-one). They said they function better as individuals when they are engaged in a couple compared to when they are alone. These respondents were willing to share their lives with somebody else and to leave behind a long period of loneliness. Although they were afraid of the virus, and they did not know anything about how life was with HIV, they report that looking for companionship or for having somebody close to them was stronger than their fears of the disease.

A good example of the previous situation is presented by Juan, a man in his early twenties. He reports wanting to become infected and has the romantic idea of dying with his partner, even if he had met recently his partner, an idea that was reinforced through stories he had heard or seen in films. He describes the way he met his partner and the role

the partner played to improve the respondent's quality of life, making some sense of what respondents view as chaotic. This respondent reports having met his partner at the age of eighteen in a bathhouse in Mexico City. After physical interaction, they exchanged telephone numbers and dated for about one month, during which time they decided to be tested for HIV. To the surprise of both of them, the respondent, who had a list of over 1000 sexual partners, received negative results. The partner, who was not so "experienced in the gay world," received positive ones. When asked what it meant for him to know that his partner was HIV-positive and he was negative, the respondent said that he had very low self-esteem and that he

> *had seen films [. . .] about HIV, in which people were still dying of AIDS. In [another movie] the main character dies with his partner standing by him in a Hospital. Then I wanted to do the same with another person, to be with him and see him dying in the hospital, next to him. That's what made me stay with him [to continue the relationship]. [I also wanted him] to infect me so I could leave this world [. . .] [This was due to] suicidal tendencies basically.*

For Juan, another reason to continue the relationship was that he had found in his partner support and affection that allowed him to improve his self-esteem. After having contact with many men, his partner was the first person with whom he had felt connected and who provided him some sense of belonging:

> *He was the first partner that I really had. He substitutes a little bit [for] my father's affection [. . .] certain things or problems that I have with my family. He gave me affection and I had already been looking for affection in other persons and I had not found it. Initially I was [. . .] I do not know, like looking to become HIV-positive and die. Later [after some time in the relationship], my partner started to make me feel better, to improve my self-esteem.*

When asked why he decided to continue the relationship, Juan also mentioned that having a handsome boyfriend helped him to improve his self-esteem. He liked to be seen with a guy whom his friends thought of as charismatic, interesting, and supportive. The respondent reports that he would not like to regret breaking up with his current partner in the future because he knows that other men are willing to engage with his partner. These are his words:

I have other big defects, like I am very possessive, very obsessive and very apprehensive. My former acquaintances that could potentially have been my partners always ended up running away from me because they received at least fifteen daily phone calls from me. Then I meet this boy [my current partner], who is very handsome, very attractive and that pays attention to me. Many people that I know would do anything to be with him, in spite of his HIV. My partner also has many good friends that would like to be with him. One of them was going to be in the Olympic Games [. . .] so you can imagine what kind of body he has [. . .] [He also knows my partner's sero-positivity and he does not care, it is not a problem for this guy]. So that's another thing that has deterred me from leaving him, because he has a nice body, that is to say, he is handsome and gallant. I know that if I leave him, I will regret later, and by the time I want to come back he will not be available.

In conjunction with emotional and affective ties, material reasons also factored in to continuing the relationship. This was the case for three men who received information about their partners' discordance a few months after the relationship started. They state that by then some affective bonds were already developed: kindness, companionship, and mutual sexual desire were favored for continuing the relationship. But they also mentioned that other factors in the relationship: with the economic and mentoring support from their partner they were able to finish college or they had a place to live. Some of these respondents were also already acquainted with some information about HIV, and they guessed about their partners' HIV status before they were informed by their partners. They noticed the great quantity of medicine that their partners were taking, or they got suspicious because of the explosive and unpredictable behavior of their partners.

d) Partner's Integrity and Honesty

Another group of respondents also reported that they decided to continue or start the relationship because of the honesty they perceived in their partners (five out of twelve). The fact that their partners disclosed something so intimate and private was taken as a sign of trustworthiness, especially when this disclosure occurred when they didn't really know each other. For these respondents, people cannot be disaggregated into different dimensions and judged by only one aspect of their lives, in this case their HIV sero-status. Respondents indicate people should be judged in an integral manner. Ramiro,

in his late twenties, in a relationship for five months at the moment of the interview, reports that his partner told him about his HIV status on the second day they were dating. This respondent only hugged his partner and decided to continue because of the characteristics he perceived in him:

> *his sincerity more than anything, and his honesty to tell me [that he was HIV positive], and everything else too. His feelings, his way of thinking, everything [. . .] you cannot disaggregate a person into different qualities because then it would be as if you were buying something. I believe that you should accept a human being as he is, in an integral form. You cannot say: I like his character but not his body [. . .] or I like his body but I do not like the way he thinks. I don't think it should be like that.*

It was common that respondents whose partners disclosed their HIV status at the beginning of the relationship had mixed feelings due to fears of infection and attraction to the person they had just met. For most of them this was the first time they were involved with someone with HIV. That new situation made them question themselves about what they really wanted in a partner. They indicate that in the end a romantic vision of the world prevailed in which the virus and 'love' did not have to be in direct opposition:

> *When I met my current partner and he told me he was sero-positive, I thought: "well, I cannot go throughout life asking people whether they are sero-positive or not, in order to decide whether I can have interest in a person. That is to say, I am going to be interested in a person for what the person is and not for his sero-positivity. So, his disclosure moved many things in me [. . .] Obviously the first thing that you think is the possibility of becoming infected [. . .] and then you think that you cannot go throughout life asking people 'are you HIV positive' [. . .] 'because if you are not then I can be interested in you, but if you are positive then you are discarded automatically'" [. . .] So in the beginning you have certain kind of doubts about what you really want with that person (Jesus, twenty-five).*

e) Association between Risk of Infection and Pleasure

A particular number of respondents report the sense of danger that a relationship with an HIV-positive man represents (two out of twelve). The partners certainly had many things in common with respondents, which made the relationship attractive: respondents report affection, sexual desire and chemistry between both of them. But an important ingredient was the perception of doing something forbidden and risky and

playing with that risk to obtain sexual satisfaction. For such people the uniqueness of this type of relationship brought excitement to their lives. For one respondent, Roberto, twenty-six, such excitement was "medical and social." His partner was HIV-positive and he was also male to female trans-gendered. Roberto took these two elements as a challenge in his life. The medical risk was to avoid infection during sexual interaction, while the social risk was avoid social ostracism for dating a transgender man. In this last respect, his gay friends usually did not get along with his partner, while with his straight friends it was difficult to introduce him because they did not know about the respondent's sexuality. When asked about the reasons for engaging in this relationship, Roberto says this: "*I found a common chemistry with her: comprehension, understanding, things that other people [men or women] did not give me. In addition it was the fact that I like danger and strong emotions. This relationship is new for me and the social danger that it represents seduces me.*

6.4 Conclusions

This chapter describes the initial reaction and adjustment of respondents to their condition of being a member of a HIV-discordant couple. It recuperates the premise that people's perceptions of things have consequences regarding their decisions and behavior. It recognizes that such perceptions are the product of individual interpretations placed in specific sets of social and cultural interaction. The first part presents the context in which HIV-positive men were diagnosed and how they believed they were infected. In many cases infection occurred in previous stable relationships or through casual sex when men were not used to wearing condoms. When infection occurred from a previous stable partner, respondents mention particular perceptions of condoms as a factor for not using them, in particular their association with unfaithfulness, and the potential problems in the relationship if someone brought the issue up, including their perception of a negative effect in the interaction with their partner. When infection occurred through casual sex, men argue that they have not used condoms due to the enhancement of sexual pleasure and the illusion that with time they would get to know the unknown sex partner better: a

behavior that also resulted from respondent's personal desire and their interpretation of somebody else's reaction, and as such, from the link between individual and social factors. Other men, regardless of the type of relationship by which they were infected, mentioned that they truly believed that AIDS was an invention of the mass media to stop homosexuality, a rumor that was present among their gay friends and acquaintances. Such beliefs highlight the importance of immediate social networks as a source of meanings upon which respondents made their own interpretative judgments. These men never used condoms and they described themselves as belonging to a generation where condoms were unpopular. A final group of HIV-positive men report that they probably were infected through a one night stand with a man they had known for years. Knowing that person for a long time and perceiving him as someone with the same social background made respondents trust the person and feel comfortable not wearing condoms even if in other casual encounters they were used to wearing condoms.

This chapter also presents the reaction of HIV-negative men to their partners' HIV status and the decisions they made to continue the relationship. Men of recent relationships at the moment of HIV diagnosis/disclosure report that disclosure as a sign of trustworthiness and reliability. They also indicate that in spite of the recent relationship, they found a sense of belonging with the new partner which made them improve their self-esteem and leave behind a sense of loneliness. Other men in this group also reported as a factor to continue the relationship the excitement of risk and danger that the relationship represented in medical and social terms.

Chapter 7: Effect of HIV Discordance on Sexual Life

7.1 Introduction

The theoretical premise underlying this chapter is that knowledge is not the only basis on which people take courses of actions. The chapter shows that people aware of their HIV discordance do not necessarily have protected sex, in spite of having the information about how to avoid risky practices and feeling themselves at risk of infection or re-infection. The main topics covered are whether there are changes in the frequency of sex, type of sexual practices, and condom use after awareness of HIV discordance. Within each one of these topics the analysis pays attention to two different moments in which the couple became aware of their different status regarding HIV: at the start of the relationship when one member discloses his HIV status to his new partner, or after a certain time of being together when both of them are tested and only one of them gets positive results. The analysis also highlights different attitudes among HIV-negative and HIV-positive men when these exist. In many situations, both partners reported similar experiences and perceptions on a variety of topics, regardless of their HIV status.

This chapter is mostly concerned with drawing a general picture of different responses in the sexual lives of the couple after their awareness of HIV discordance. Some of these responses involve protection, but some others show less concern with infection. Each one of them is associated with different perceptions of sexuality and protection in their relationships which in turn, are the result of an interaction of individual, social and cultural factors.

7.2 Impact of HIV on the Frequency of Sex

a) Initial Period of Adjustment

The effect of HIV discordance on the sexual life of the couple varied according to the moment when both members became aware of their discordance. In some situations, HIV-positive men already knew their status before starting their current relationship and

disclosed it within the first month of relationship (four out of nine couples and five out of seven men whose partner was not interviewed). In most cases participants did not have sexual intercourse before disclosure. Within these couples, HIV-negative men experienced an initial period of understanding the mechanisms of the disease and accommodating to the situation. They report practicing only kisses, hugs and caresses and in some cases mutual masturbation. For the most part they did not experience oral sex or anal penetration, and when they did in very few cases, they report that it was not on a frequent basis. Once these men decided to continue the relationship and were more informed about the means of transmission of HIV, they incorporated anal and oral sex as part of their daily sexual lives in conjunction with precautions to avoid infection or re-infection. Later, as it will be seen in a subsequent section, some ventured not to use condoms.

HIV-positive men aware of their status before starting the current relationship also report an initial period of mutual adjustment. For many of them this was their first discordant relationship, and they did not want to force their partner to have sexual intercourse. They were afraid of passing the virus on to them. In many cases HIV-positive respondents were simply looking for acceptance and were happy with spending time with the new partner. During that period they report having exclusively kisses and touching and at most mutual masturbation. It was mostly when the partner was ready that they practiced anal sex or oral sex using condoms. HIV-positive respondents indicate that once they overcame their own burden of fears, they started having sexual intercourse as they used to have before being infected.

Although most HIV-positive respondents reported a period of adjustment with their partner before having sexual intercourse (seven out of thirteen), there were a number of them who also had sex the first or second day they met their partners (six out of thirteen). According to respondents, their partners were willing to have protected anal intercourse right after knowing the respondents' HIV status, and during the first years of the relationship the frequency of sex was not a problem. It was time in the relationship that made respondents' partners to stop having desire for or interest in sex. In this respect,

Raul, a man in his late forties and with fourteen years of being HIV positive, describes the attitude of his partner when he told him his HIV status:

> *Immediately after I met him I told him that I was HIV. We were already at home. Before having any sexual contact I told him that I was HIV-positive. He told me that there was no problem as long as we wore protection. And we did it in that way [. . .] The first 3 years he was very passionate. [. . .] In little time we had sex two or three times. I do not know if he got tired or if he met another person [. . .] or if he started to realize that he could get infected [. . .] But he started to withdraw from me while in bed .*

In situations in which HIV was diagnosed after a certain time of being together (a lapse that goes from one month to twenty years), the consequences for their sexual lives were different (seven out of sixteen couples and five out of twelve men whose partner was not interviewed). The more time being together before diagnosis, the more respondents experienced an immediate detriment to their sexual lives due to fears of infection and feelings of guilt and betrayal. For the most part, HIV-positive men experienced strong fears of infecting their partner. They were afraid that condoms could break and their partner could accidentally enter into contact with respondents' fluids. In addition to this, some respondents also report that lack of sex was accompanied by dysfunctional problems and a debilitated immune system at the moment of diagnosis or by the stress and shock caused by the news of being HIV-positive. An HIV-positive man who was asked whether the presence of HIV affected the frequency of sexual interaction with his partner, indicated,

> *Yes, especially in me. I was afraid of doing it [sex] in the beginning because I didn't want to infect him. I did not want to hurt him. As I was sick [with pneumonia] I could not have sex with him, but there was a moment in which it happened. I was worried that the condom could break, that it could fail, that something could happen. In fact as [before] we always used cream instead of lubricant, [now] I decided to use lubricant. I bought water based lubricant for more protection and to avoid hurting him (Ismael, thirty-five).*

Similar fears of passing the virus to the partner are reported by another HIV positive man, Marcos, who was diagnosed with HIV after one year of the relationship. Although his partner did not show feelings of rejection or mistrust, the respondent was

terrified of the possibility of infecting him. Marcos did not want to have sex, especially after his partner's test results were negative: "*After knowing the diagnosis we needed some months to have sexual relations again. But it was not because of him, but because of me. I did not want to have sex, even more after knowing he was HIV negative. I said, 'no, I am afraid of infecting you.'*"

For Ismael, like for other HIV-positive men, being diagnosed with HIV also created a tense atmosphere in the relationship. In addition to his own fears of infecting his partner, there were mixed feelings about having cheated, even if nobody mentioned anything about that:

> *Initially [my positive results to the HIV test] were shocking for him, because they implied that I had cheated on him [. . .] and that he also had the virus, in spite of the fact that we have always used condoms. The relationship cooled off a bit. We had very "cold weeks," in which nobody would mention the topic. We avoided having that conversation. Later we talked [. . .] because I, myself, do not know how I was infected, neither why. I do not remember if there was a time in which the condom broke or something like that. We talk and decided to continue the relationship and the things are better now. I believe that now we are closer than before. He takes care of me more. He is vigilant about the medicines and everything.*

Within couples aware of discordance after a long period in the relationship, many HIV-negative respondents experienced rage and anger after the positive results from their partner. Respondents initially felt that infection occurred due to their partners' unfaithfulness, leading to weeks or months of no sexual interaction at all. According to some respondents, partners made up a series of reasons for being infected that were hard to believe. Respondents did not believe in such reasons, and they felt that their partners were lying about the causes of infection. What they consider lies and betrayal caused more problems in the relationship. The previous trust and reliability upon which their relationship was based on was drastically affected. An immediate effect of knowing the discordance brought not only a pause in their sexual lives, but also made the communication within the couple difficult. Many felt uncertain about the future of the relationship or whether they were already infected. Some initially thought to be also infected by their partners and that it was only a matter of time to experience the first

symptoms. Repeated tests indicated, nevertheless, that they were not HIV-positive. These respondents constantly mentioned that because of their new situation they regret not being able to have the same type of sexual practices as before due to fears of infection. Even after incorporating protected sex, the relationship suffered a certain degree of deterioration, and they continue with strong fears of becoming infected. After partner's infection, HIV-negative men do not have sex if they feel hurt or if they dislike the way they are performing sex. If before infection there were situations in which they would perform sex to satisfy their partners' desire, now they would look out more for their own security and comfort.

An HIV-negative man, Joaquin, forty-three, reports how his partner was diagnosed with HIV and his own reaction afterwards. They have been together for about fifteen years, and they found out about their discordance three years ago, when the partner was hospitalized due to pneumonia. He says,

> *we had a lot of trust in the relationship, a lot of respect, but he [my partner] argued that he was infected visiting the pedicurist or the dentist. That is something that I did not accept, because I have taken courses on safe sex. Many years ego, I even asked him to learn to use condoms, because I did not use them, but knowing about the risk I decided to make that suggestion. But he did not want to. In fact he [still dislikes that I carry condoms with me, but I do not care. After so many years together he ends up infected, well, it is very difficult and it puts me on alert to protect myself. [. . .] [Our discordance] affected our life, because even after 3 years that [. . .] that he is infected, I have had to go through a process of assimilation, as well as him. Of course, the first thing that he did was to withdraw sexually from my life, something that it is not fair.*

Luis, HIV negative and forty-two, also reports how he discovered that his partner had HIV and how he felt after hearing the news. After five years of the relationship the partner was diagnosed with the virus. Now they have been aware of their discordance for two years. The partner had a medical problem and the physician asked for a test to Elisa, which surprised the respondent. He never thought that it was necessary to have a test for HIV, and both of them were tested. He describes the shock and disappointment experienced when his partner's test was positive for HIV:

we were both present when we received the results. [. . .] The physician gave me the results first and they were negative, and I was sure that my partner's results would also be negative. Nevertheless, that was not the case, so it was a terrible change [in our life]. I cannot describe it very well. What I know is that it was terrible. I wanted to cry, to scream, to know who was responsible or why [my partner was infected]. [. . .] [At the moment] We apparently had information [but] I associated HIV/AIDS with death. I did not know how long, why or what I was going to do [. . .] [After the diagnosis] trust decreases, because in the beginning trust was total. You do not think about the consequences and you do not take precautions. Now, you use precautions, but with fears and lack of trust, or uncertainty about the use of condoms and thinking that at any mistake I can get infected.

The moment of crisis in the relationship led to a decrease in the frequency of sexual interaction, so when I asked him whether there had been a change in the frequency of sex due to their HIV discordance, Luis said: "*I think so, because before we had a much more active sexual life and now it has decreased. [Before, we probably] had sex everyday during the week and now we have it two or three and, sometimes, only one time per week).*

b) Resuming Sexual Activity: Couples Aware of Discordance after Long Period in Relationship

Resuming sexual activity occurred after these couples learned more about the disease and the forms of prevention. These couples decided to solve their problems and to look for information that helped overcome their fears. They attended support groups and visited physicians. In this task the help from the HIV-negative partner was essential. The diagnosis was so frightening that it usually leads to immobilization for the partner diagnosed. Men in their twenties increased the frequency of sex after an initial period of crisis that followed diagnosis. If they did not wear condoms before, they introduced them into their sexual practices; if they had already been using them, they simply renewed this practice. As will be seen later, there were nevertheless cases in which condoms were still not used.

Marcos, an HIV-positive man who was diagnosed after one year of his relationship, indicated that for six or seven months they did not have sex because he was afraid of infecting his partner. In this case, the partner did not reject the respondent, and, on the contrary, looked for sexual intimacy. It was only after making several visits to the physicians and workshops on safe sex that he learned to wear condoms and to have sexual intercourse again with his partner. Before he had never used condoms, even with previous partners (from whom he was probably infected), because he associated condom use with promiscuity:

> *After knowing the diagnosis we needed some months to have sexual relations again. But it was not because of him, but because of me. I did not want to have sex, even more after knowing he was HIV-negative. I said: "no, I am afraid of infecting you." (In a clinic) they explained to us many things, they invited us to workshops on safe sex and protected sex. That changed many things in my life, and also in my partner. Since then we had to change many things with regard to sexuality. [Before] [. . .] I did not want to have sex. I think that he was more mature [than I was] to understand [my HIV positivity] and to approach our sexuality, because I did not want to have sex. It took us six or seven months to have sexual relations [and we finally had them] because he wanted to have sex. I said no, and he asked me: "why not?" I answered: "because I am not the same. I am sick." I used to say to myself that I was sick. He told me that I was fine. In spite of knowing the diagnosis, he told me that I was fine and then we went to many support groups. At that time we looked for psychological help for me, to make me closer to him again. Because he would touch me and I rejected him. I would kiss him and touch him, but if he wanted sex with penetration and all that, I did not want that. I did not want to masturbate me or him.*

Another man who disclosed his HIV status to his partner after nine months of relationship (Gregorio, twenty-eight), describes that initially his HIV-negative partner was very mad for being taken as a fool, and he did not want to be touched. But after his partner adjusted to the situation, they had sex everyday, even more frequently than what the respondent really wanted. After almost three years of being together, the HIV-negative partner still presents more interest in sex. The respondent argues that such difference in libido is due to their difference in age and to extreme loads of work: the

respondent is four years older than his partner, and he has to commute at least two hours a day to go to work, so when he arrives home he is too tired to have sex everyday:

> *At the beginning [we stopped having sex]. My partner basically did not even want me to touch him. I said, "I need to give him some time so he could understand it." After he assimilated the situation, it has been great for me. It has helped me a lot. I have not had any problems because of that. Not really. No. [Now] the problem that I have with my partner is that he always wants me to be on top of him. I feel that he loves me a lot. But I feel that I do not have the same physical condition than some years ago, because I get tired too much. He wants to have sex everyday and I do it [. . .] but there are days in which I said: no, I am sleepy.*

A group of men in their late thirties or forties indicates that the diagnosis of HIV in one of them after many years of the relationship did not have a significant impact on the frequency of sexual relations. These men, whether they have HIV or not, indicate that the decrease in sex they have experienced is due to the natural history of the relationship, their many years living together, and the difference in libido that had become visible throughout time. In some situations, respondents report a certain degree of flexibility in the relationship, and sexual affairs were accepted as natural. Problems with cheating or distrustful feelings have not emerged as a consequence of the HIV diagnosis. Adrian, an HIV-negative respondent in his early fifties, for example, expresses no concern with his partner having gotten HIV through casual sex. Adrian indicates that for him it is totally understandable that after twenty years of living together, the partner had an affair where he probably was infected. In fact, this respondent reports also having had casual sex while committed to his current relationship. He says that he even felt guilty when they both suspected that his partner had HIV. As Adrian had practiced casual sex more frequently than his partner, he thought that if his partner was HIV-positive, it was because he had infected him. After both of them were tested, contrary to his own belief, only the respondent was HIV-negative. When I asked him about the impact of HIV in the frequency of sex with his partner, he said,

> *We had been living together for twenty years [when my partner was diagnosed with HIV] and you know that passion decreases a little bit [in a natural way]. By then the frequency was not important, so in terms of frequency everything is the same, but there were some other changes:*

changes in the way of making love. There were many changes, especially to take care of him, but also to protect me. The diagnosis did not affect too much the frequency. I understand that if my partner is now HIV positive, it is due to an accident. I perfectly understand that after twenty years of relationship, my partner has had an affair [in which he probably got infected].

Valentin, thirty-eight years old, is another respondent who reports that the news of HIV discordance did not initially produce a major change in the frequency of sex. He has been engaged for the last fifteen years, and his partner was diagnosed as HIV-positive in the last four years. During the first eight months, after knowing they were HIV discordant, everything continued the same as before. Nevertheless, after those initial months they stopped having anal or oral sex, and now they rely almost exclusively on mutual masturbation, touching, hugs, and so on until the present. The reasons couple stopped having anal sex is the presence of hemorrhoids in the HIV partner that cause pain and that increase the presence of blood and thus chance of transmission to the respondent.

7.3 Impact on the Type of Practices

a) Knowing Discordance at the Beginning of Relationship

Couples who know of their discordance since the beginning of the relationship report that, after an initial period of exclusive touching and kissing, they incorporated anal and oral sex into their sexual lives. When these couples started practicing anal sex, the HIV-negative partner played the insertive role almost exclusively because the couple considered this practice less risky. They perceived that if the HIV-negative partner was not penetrated there were fewer chances for him to become infected. The primary concern was to avoid his sero-conversion, and they placed the chances of re-infection of the HIV positive partner as of secondary importance. Later, as time progressed and they gained familiarity with safe sex, these couples practiced anal penetration in both partners, and, in some cases, even without condoms.

Where exclusive preference for only one role existed regarding anal penetration, respondents ended up practicing more frequently the insertive or receptive role depending on their own preference and regardless of what they considered as a riskier practice. It was basically in couples in which no exclusive preference existed in those roles that HIV-negative men continued to practice the insertive role more frequently to reduce the risk of primary transmission.

With regard to oral sex, most HIV-negative men reported receiving oral sex from their partners, even ejaculating in their partners' mouth. They considered this a low-risk practice for themselves and safe for their partners. They mentioned that they get constant check-ups with physicians to make sure they do not have any medical problem and that their partners are also vigilant about not having any oral problem that could potentially lead to infection through oral sex. More commonly than not, HIV-negative respondents do not perform oral sex on their partners, or they avoid contact with semen. The risk of infection through pre-seminal liquid is a constant in spite of their efforts to minimize their risk.

It is interesting to note that some HIV-negative men mentioned that although they do not have semen intake with their current partner, they used to engage in such practices in previous relationships. The rationale for this practice was that semen intake implied certain emotional complicity with their partner. They report having done so because they were extremely "in love" and sex meant more than just pleasure. In this context, sex with the partner was like a "ritual." For instance, when I asked an HIV-negative man about what he felt caused him to intake semen from his previous partner, he said,

> *Aaah!!!! It was marvelous. I was really in love with that person. Perhaps he has been the only person that I have really loved with my whole soul. I was really in love. And intaking his semen was a plus for me. It was like a ritual, because I felt so involved emotionally with him. I was so in love that it was like a ritual for me. It was not only sex for sex, it involved a whole ritual in-taking his semen [. . .] and it has been the only person from whom I have experienced that. Later [. . .] I realized that I should have not done that, even if I was deeply in love. But when I talk about it was a ritual [. . .] [I mean that] it was a kind of eating each other. The desire and passion for him was so much that it was like eating him. You know what we have in mind (Jesus, twenty-five years old).*

b) HIV Discordance is Visible after Long Period in Relationship

Respondents whose partners become aware of their HIV status a long time after the beginning of the relationship report few changes in their sexual practices as a consequence of HIV discordance. Many of them also report an initial period during which they stopped having sex at all. Later they resumed sexual interaction, including anal and oral sex. In the case of anal sex, HIV negative men also tended to play the insertive role predominantly, especially if this was in agreement with the couple's general preference. Otherwise the HIV-positive men played the insertive role and the HIV-negative men the receptive role to comply with their own preference. It seems that by the time these couples discovered their HIV-discordance, both men had already established within that relationship the sexual practices they felt more comfortable with: sometimes leaning more toward one role than the other, and some other times practicing penetration in both directions. More respondents mention that after diagnosis they were simply more careful, avoiding contact with semen or blood from the HIV-positive partner.

With regard to oral sex, many HIV-negative men report that after awareness of discordance they do not perform oral sex upon their partners as frequently as before. When they do it, they do not have direct contact with their partner's semen, a practice that in their own words they now miss. Many HIV-negative men, nevertheless, have been in contact with pre-seminal liquid while giving oral sex. They know this practice conveys certain risk, but they consider it among the lowest risk practices. In this way, when it is a matter of giving oral sex, it is more often that HIV-positive men give it to their partners than otherwise, also taking precautions about not intaking semen to avoid any potential reinfection.

Among couples in long-term relationships, some cases deserve special attention for the risk which they incur on a frequent basis. After knowing discordance to HIV, some couples continue not wearing condoms in anal or oral sex with internal ejaculation. They may even incorporate some of these practices after the diagnosis of HIV in one of them: Guillermo (forty-four years old), for example, indicates that during the first year of the relationship they wore condoms all the time. As his previous partner was HIV-positive, this respondent wore condoms because he did not want to be blamed in the

hypothetical case that his partner contracted HIV somewhere else. Guillermo was HIV-negative and he wanted to know his partner's HIV status before having sex without condoms. After one year in the relationship the respondent's partner got tested for HIV and the results were positive. He was probably infected through a previous sexual contact with a friend.

Having had two previous HIV-positive partners, Guillermo was not shocked by the diagnosis and showed total support of his partner. He knew that with proper care his new partner could have a good quality of life and live a long time. It was only after they knew about their HIV discordance that they practiced anal and oral sex in which the infected partner played an insertive role. Guillermo and his partner mention that they avoid internal ejaculation, or when the partner is going to orgasm he then puts a condom on. They perceive these as less risky practices, but Guillermo also mentions that he cannot be totally sure whether his partner has avoided ejaculation when he does not have the condom on. He basically trusts his partner in taking care of the respondent's health. As will be seen later, refraining from ejaculation and compromising his own pleasure is perceived as proof from his partner that he cares and protects the respondent's well being.

7.4 Impact on Condom Use

a.) HIV Disclosed at the Beginning of the Relationship

Most couples in which the HIV-positive partner disclosed his sero-status at the beginning of the relationship report having used condoms all the time for anal sex. For them, wearing condoms is a given; it is mutually understood that they need to use condoms all the time during anal sex. Nevertheless, some couples also report that at some point they have not used them (five out of nine couples and four out of seven men whose partner was not interviewed). Some HIV-positive men in this situation report that even after disclosing their sero-positivity, their partner would not want to use condoms for anal sex for considerable periods of times. Respondents indicate that even after having the common agreement of wearing condoms for anal sex, they would not care due to emerging passion at the moment of having sex. In these circumstances HIV-positive

respondents indicate that wearing condoms is a common responsibility and that their partners are making a choice by deciding not to use them. Respondents assume that such choices are based on a lack of excitement with condoms, or perhaps the partner thinks he is already HIV-positive too. To this regard a man who was diagnosed with HIV two and a half years ago (Rodolfo, thirty-eight years old), indicates that his current partner with whom he has been with for one year, did not want to use condoms during the first months of the relationship, even after being notified of the risk of infection. At the third month of the relationship this man was tested and the result was negative. During that period they did not wear condoms at least five times. When asked about why his partner did not want to use condoms, Rodolfo said that perhaps his partner had low self-stem by taking the risk of being infected, but that, in the end, he had made a choice and was partially responsible for having unprotected sex:

> *The first months [my partner] did not want to use condoms [even after I told him that I was HIV positive]. My friends told me: maybe he is already positive. They also told me: be careful, watch out [. . .] [probably he has something wrong] and I got worried, but [. . .] when you are there [having sex] you behave in a very different way of what you think. When you are in a sexual relation you let yourself go with passion and everything become visceral [. . .] As people say: hormones kill neurons. Later he got tested after three months in which we had sex without condoms five times approximately. He did not get excited with condoms. When he was tested the results were negative.*

In couples where condoms are not used all the time, men perceive that the uninfected partner lowers his risk of infection by playing an insertive role. In extreme cases, they also say that there is no risk at all if they just limit their sexual activity to penetrate even without condoms. Raul, who is HIV-positive, reports, for example, that initially they were both cautious about wearing condoms all the time. He disclosed his HIV status since the first day they met and his partner agreed to have protected sex. But with time, the uninfected partner first got the idea that only persons that behave passively in terms of penetration were at greater risk of infection; later he thought that there was no risk at all if he remained playing the insertive role exclusively. Under these assumptions, they had multiple sexual encounters during which they did not use condoms. The partner

has not gotten any tests for HIV because he does not perceive himself at risk of infection. It is possible, too, that he is afraid of being diagnosed with HIV, so he prefers to hold on the idea that there is no reason for him to worry as long as he is not penetrated. Probably this is a way for him to escape from a potentially harmful consequence of his behavior.

b) Couples Who Knew of Discordance a Few Weeks/Months after Formation

Couples where HIV discordance was disclosed or discovered a few weeks or months after the relationship started also report using condoms constantly for anal sex. When they had sex before the partner disclosed his HIV status, HIV-negative respondents say that their partners were careful and took the initiative in using condoms all the time. After disclosure of HIV both of them reinforced mutual protection and avoided contact with bodily fluids. Nevertheless, some exceptions to this situation deserve attention.

Diego is an HIV-negative respondent who reports that his partner did not mention his HIV status the first five or six months of the relationship, a time during which they practiced anal sex without condoms. When Diego became aware of his partner's discordance, he started using condoms to avoid infection. After getting tested for HIV, Diego found he is still negative. Now he tries to be consistent in the use of condoms, but he does not use them all the time he has anal sex. Due to the passion of the moment and the joy of sex, Diego argues that he forgets his partner is HIV positive. When I asked what changes awareness brought into their sexual life, this respondent explains that

> *At the beginning [there were changes], not in frequency but in being more cautious. We have tried to protect ourselves but suddenly because of the heat of the moment or because I am very distracted [we do not use condoms] [. . .] sometimes I forget and I live [in the moment]. I forget that he has AIDS (sic) and I live thinking that he is completely healthy. I just forget. After the news there have been some situations in which we have had sex without condoms, knowing that it is something wrong, but we have done it. It is the exception and obviously every exception could be the bad occasion [when I could become HIV-positive]. But we have tried to protect ourselves more [. . .] using condoms, but not in terms of [type of relations] or frequency of sex.*

One couple also mentions that after one month of dating they both were tested for HIV. This was a surprise for both because the person who resulted negative in the test

had a long history of unprotected sex with multiple sexual partners, and the person who resulted positive had been more careful in his sexual relations using protection most of the times and having long-term relationships, rather than casual encounters. They report that before the test they did not use condoms for anal or oral sex, and after the results of Elisa they started using them. Nevertheless, one month later they stopped using condoms again for certain periods of times. Their use of condoms since then has not been consistent and, on average, they have used condoms 50% of the times in the six years of the relationship they currently have. When I asked why they were not using condoms consistently, knowing the risks of infection and re-infection, the HIV-negative partner mentioned several reasons: for this man, not wearing condoms originally represented that he had found the person with whom he was going to spend the rest of his life. It was a form to express his commitment, after a long journey of searching for a man that could give him security and protection.

Some other times this couple simply ran out of condoms and they did not care about infection or re-infection, since they were willing to share same destiny. Other times respondents indicate that wearing condoms was a problem for sexual performance because they lose their erections or they feel that condoms are too tight and hurt, reducing physical pleasure:

> *Before the 1st month [in which we were tested for HIV, our sexual practices] were without condoms, because I thought he was going to be the last person with whom I was going to spend my life, because I had found my other half Then [I thought] I was not going to have sexual contact with anybody else, but only with him, so [the sexual practices] were without condoms. After knowing about [our discordance], he tried to use condoms but not many times. When he had the condom on he lost the erection. On the other hand we also had a time in which I forced him to have sexual relations without condoms. I forced him in the sense that: "hey, if we are going to have sexual relations is going to be without condoms." Maybe this was due to something I told you before: my desire to be infected with HIV. Among other things it was also because I did not work very well with condoms: condoms were too tight for me. I did not feel pleasure at a 100% level. There were times in which condoms were hurting me due to the lack of sufficient lubricant and sometimes even the lubricant was hurting me. Then I prefer it bareback (Juan, twenty-four years old).*

According to this young man and his partner, he suffered from depression and had tendencies towards suicide, especially before he met his current partner. He found himself lost in sexual compulsion without really achieving self-realization. When he met his current partner, he became an icon for solving many of respondent's problems, and the relationship quickly developed into strong mutual attachments. The partner became a solid image that helped to make sense of his life. As he perceived his partner as the only valid attachment to life, he did not care about becoming HIV-positive and dying with his partner. He even reported fantasizing about the idea of death and love as two things worth pursuing with his partner. His partner describes this young man as apathetic to life and with a strong need for being cared for:

> *He [my HIV negative partner], per se, showed indifference to life. He was apathetic to continue living. His family context was horrible. His sexual life was terrible [too]. He knew I had a terrible disease. He was in a sexual need of finding the care and love he had never had in his life. Then when he finds all that in me, he suddenly experienced a feeling of belonging, and says: without him [that is to say, me] there is no sense of my existence, if he is going to die before the end of this year, I want to die with him [too]. [My partner thinks]: " what I want is to die, but as I don't dare to shoot myself with a gun or jump from a building, then maybe I can become infected" (Oscar, forty-one).*

Another reason this couple did not use condoms is their view that chances of HIV transmission within the relationship are very low because the HIV-positive partner presents undetectable counts of viral load and high numbers of CD4 cells. They report that, according to physician's opinion, the HIV-positive partner is in very good health conditions. In fact, his heal may even be better than most people without HIV because his CD4 cell counts are higher than normal levels. In addition to this, the HIV-negative partner also had sexual intercourse with other men that were also HIV-positive, and, according to several tests to Elisa, he continues to be HIV-negative. During his long history of unprotected sex with multiple partners he has being diagnosed with many other sexually transmitted diseases, but he keeps showing negative results to Elisa. Their rationale is that if transmission has not occurred after many years of unprotected sex,

there is probably something in the HIV-negative partner that makes him immune to HIV and with a partner with low viral loads the risk in extremely small:

> *[My HIV positive partner] tells me that due to his current HIV situation there are 95% chances of no infection if we had sex without condoms, because his viral load is very low [. . .] and we have seen this in the clinical analysis. That is why I feel certain security to have sex without condoms. Nevertheless, there are also times in with even knowing that, I feel regret. Then I use condoms (Juan twenty-four).*

About this same issue of not wearing condoms his partner comments:

> *[My HIV negative partner] had constant sexual practices, once a month, with two persons who died because of AIDS. My partner had sex with them in moments in which they were close to death [. . .] [and his results to Elisa] were negative and negative and negative. Then there is certain idea that my partner can be of those persons with certain immunity to HIV. He had all other STDs. All of them and he has received medical treatment. He is an expert [. . .] [but not HIV] (Oscar, forty-one).*

c) Couples Who Became Aware in the Course of the Relationship

Among respondents who became aware of their partners' HIV status a long time after the relationship started (between 7 months and several years), there are couples who used condoms on a regular basis before one of them was diagnosed (two out of five couples and three out of five men whose partner was not interviewed). After diagnosis condom use was simply a task they had already learned and they simply reinforced precautions. Other couples did not use condoms on a regular basis or at all before diagnosis (three out of five couples and two out of five men whose partner was not interviewed). They perceived condoms as unnecessary in stable relationships or as leading to casual sex. After awareness of HIV discordance, these couples report that it was hard to incorporate condoms on a regular basis because it was not part of their habits. They had learned to have sex without condoms and to experience touching and their partners' skin in a different way. With condoms, physical pleasure and intimacy lost their spontaneity and the inherent character of "connecting two bodies/souls."

Uninfected partners in these couples also reported that they were not totally convinced of not having HIV following their partners' diagnosis. After a long time of having unprotected sex, they thought that it was just a matter of time for the virus to become visible. Even after subsequent tests with negative results to Elisa, respondents continued in disbelief and showed no interest in wearing condoms: *"I already knew that he was HIV- positive, but I had not been tested for Elisa. I thought that I was positive too. I thought: if we both already have the virus, then let's continue having sex without condoms" (Tomas, twenty-four).*

They also conceptualized partnership as sharing a common destiny and showing support in difficult situations. Support consisted in not wearing condoms and making the partner feel accepted. Later on they realized that they were not HIV-positive and did not need to have the virus to support and care for their partners. After a process of reflection on their experience after the diagnosis, now they think that they were unconsciously looking for sero-conversion. They also learned that even if infection had occurred, not wearing condoms still represented a threat because they would be an easier target for other infections. And if they were not yet infected, they would be exposed to a more resistant virus due to partners' intake of anti-retroviral.

Men in their late forties and fifties and in long-term relationships report not being used to wearing condoms. They indicated that their sexual lives started when AIDS did not exist, and condoms were not very popular as a prophylactic method against STDs. In addition, being in a long term relationship of more than ten or twenty years, made them unable to even contemplate the use of condoms until the diagnosis of HIV in one of them. Nevertheless, after such a long time of unprotected sex, changing their attitudes and behaviors was something difficult. They report having talked about using them, but in practice, they do not wear them most of the time. One couple indicates that if condoms are ever used, it is usually when the HIV-negative partner is penetrated, but otherwise they do not care much, as when the HIV-positive partner is penetrated. Usually the uninfected partner has played the insertive role due to the preference of both members. One characteristic of this couple is that even before the diagnosis they always avoided

internal ejaculation; they have continued this practice as a form of what they consider mutual protection:

> *Before we knew that [I was HIV positive], our relationship was without condoms. In fact we never used condoms. We did not wear them throughout all our relationship. I am talking about twenty years. We had sex and instead we were cautions of not having contact with semen or sperm and all that. The first days that we discovered [about our discordance as to HIV] we used condoms, but later we did not use them. I tried not to penetrate my partner because I have the virus. This is in addition to the fact that my partner has always been more active [in terms of sexual intercourse] than me. I am very afraid of infecting him [. . .] and it would be very easy to use condoms but I don't do it. But at least I do not penetrate him that often [. . .] although he penetrates me without a condom, for example. Since we knew about us [. . .] we have had penetration in both ways, maybe without condoms, but there has never been internal ejaculation in the mouth or behind (Jaime, forty-two).*

This couple is also surprised that after many years of not wearing condoms only one of them is HIV-positive. In this respect, the HIV-negative partner indicated that if he was not infected before, it may not happen now, and in the event that it happened, he would assume it was just a part of life.

Among interviewees, there are also cases of couples that stopped wearing condoms after knowing of their HIV discordance. This is the case in a couple that wore condoms at the beginning of the relationship because one of them had been previously in contact with HIV-positive men. That respondent did not want to be blamed in case the results to Eliza from his new partner were positive. Both of them were tested along the relationship and the member that previously had an HIV positive partner was negative, while his new partner was positive. Now they do not wear condoms for anal penetration, and the HIV-negative partner usually plays a receptive role [even more frequently than before the results to Eliza]. According to this man, penetration without condoms can usually go from twenty seconds to thirty minutes, depending on the situation. And what they do to lower the risk of infection is to avoid internal ejaculation. For the HIV-negative partner this is a proof of the care and love of his partner towards him. Similar to many other HIV-negative men who after many years of being exposed to the virus receive negative results, he reduced his fears of becoming infected and believes that

maybe he has some kind of immunity to the virus. In the potential case that someday he became HIV positive he thinks that he will receive support from his partner and this also relieves him from much of the fear (Guillermo, forty-four).

d) Condom Use during Oral Sex

With regard to oral sex, respondents do not use condoms regardless of their HIV status or moment in which they are aware of discordance. Everybody reports that latex has a disgusting flavor, making the use of condoms nonsense for this practice. Even in the case of flavored condoms, respondents do not use them because they consider that after some minutes the flavor vanishes, and they taste like plastic. Respondents also consider that oral sex poses a smaller risk of transmission or infection from other diseases, so they are not very concerned about using condoms. To reduce the primary risk of transmission, most HIV-negative men simply avoid direct contact with semen and try to stop when they feel pre-seminal liquid from their partners (eight out of ten who perform oral sex on their HIV-positive partners). Respondents indicated that contact with pre-seminal liquid or semen was more common in HIV-positive men than HIV-negative men. Most HIV-negative men in this situation report that to minimize their risk of infection, they would try not to intake any of these fluids. When they were in contact with these fluids by accident they would simply spit them out later on (Pablo, twenty-two years old) (see previous section on type of practices). To what extent this can really minimize the risk of infection, especially in the case of contact with semen, is a question that should be raised.

In extreme cases HIV-negative respondents report semen intake in spite of knowing the risk of HIV infection. Juan, for example, is a young respondent who knew his partner's HIV status few weeks after he met him. He reports performing oral sex upon his partner and receiving it from him equally. They both have mutual semen intake, and he is not very concerned about becoming HIV-positive. He has found in his partner an icon to admire and to follow because his partner has helped him to overcome many obstacles in his life. His partner has given him a sense of belonging and makes him feel loved and cared for, something that he had not found in the multiple sexual encounters he

had before. Becoming ill and even risking his life was a decision he made because of his sense of loneliness. With time he has also came to think that because his partner has undetectable viral loads, his chances of infection, even without protection, are very low.

7.5 Conclusions

This chapter describes the effects of HIV on the sexual life of the couple. The question posed here is whether being aware of the risk of HIV transmission and re-infection stimulates or reinforces the practice of protected sex. To answer this question I asked respondents to talk about their sexual habits before and after knowing that one of them was HIV-positive to see any change in the frequency of sex, the type of sexual practices, and the use of condoms. The underlying premise is that knowledge is not always enough to have protected sex, even in situations where people are aware of their risk of infection or re-infection. To understand practices of risky sex it is also necessary to know what people consider important in a relationship and what their perception of sex and condoms is. One premise for this reasoning is that people behave on the meaning that things have for them (see theoretical chapter).

Results show that after diagnosis or disclosure of HIV in one of them, most couples report an initial period of not having sexual interaction. Later, as time progresses, they incorporate touching and kisses until they resume oral and anal sex. For the most part, they use condoms for anal sex but not for oral sex. To reduce risk of infection they resume sexual intercourse with the uninfected partner playing an active role during anal sex and receiving oral sex. They continue with these roles if they both are indifferent to whether they penetrate or are penetrated, otherwise they resume the role that usually provides them more sexual gratification. In this sense, many couples go back with what they were practicing more frequently before diagnosis: penetration or being penetrated regardless of HIV status.

Despite that most couples report wearing condoms after their awareness of HIV discordance, either for the first time or continuing its use, there are also two groups of men that are still placing themselves at risk. One of these groups initially said it wears

condoms all the time after diagnosis, but when the interview went into more detail about their sexual practices respondents mentioned that sometimes they have anal sex without condoms as a form of foreplay. Penetration usually lasts from a few seconds to more than thirty minutes, although their partners withdraw before ejaculation to put a condom on or to ejaculate outside respondents' bodies, (especially if the person that is penetrating is the HIV-positive partner, otherwise ejaculation occurs without condoms).

Another group of men openly reports to practice anal and oral sex without condoms after diagnosis of HIV in one of them. These men are in total contact with bodily fluids. They used condoms during a short period of time after diagnosis, but later on they stopped using them on a regular basis. Some of them report they use condoms half of the time, regardless of who is penetrating. Others indicate they use condoms only when the HIV-positive partner plays an insertive role.

The information just summarized is important because it shows that there are men who place themselves at risk of primary and secondary infection, in spite of having the information and the means to avoid it. These men also experience fears of infecting their partners or being infected and they perceive themselves at risk of secondary infections. Nevertheless they are not practicing protected sex on a consistent basis. Some of them seem to become familiar with the situation and to take steps to risk first a little bit, like when they first engage in foreplay without condoms for a few seconds. And after testing to Elisa and getting negative results, they repeated the same risky practice but now engaging in foreplay without condoms for more time, and so on.

This chapter also briefly presents the reasons for having sex without condoms. Some of the reasons relate particular meanings attached to condoms and expectations of a relationship. They relate, for example to the perception of physical gratification per se, like disliking the taste of condoms for oral sex or losing erection. They also relate to respondents' conception of a relationship, like the need to show mutual support to a person with whom they are planning to spend the rest of their life. And finally, respondents indicate their perceived low risk of infection due to the presumed immunity of the HIV negative-respondent or to the low viral load of his partner. The following chapter will analyze some of these reasons in more detail.

Conversely, men who report to wearing condoms on a frequent basis after awareness of HIV discordance had a different understanding of their relationship. In this case, mutual support meant that in order to provide good support, each partner had to do their best to be in good health. This was a prerequisite to improving their quality of life in any dimension of their relationship: sexual, emotional, economic, and so on. This understanding of support was not automatic. Immediately after awareness of discordance many couples also reported the feeling of abandoning themselves to their fate and not worrying about negative consequences of unprotected sex. Nevertheless, this perception changed after a long process in which they talked to other people with HIV, physicians and counselors. Through the interaction with people that had a long time to think about the same situation they were able to incorporate in their own vision an element of care for avoiding infection/re-infection that was not there before.

Chapter 8: Taking Risks. Getting Familiar with the Virus

8.1 Introduction

The present chapter analyzes several situations pertaining to the risk of HIV transmission and re-infection. Some of these situations were briefly mentioned in the previous chapter. In the present chapter they are analyzed in more detail, and new situations are also presented. If the previous chapter showed that after awareness of HIV discordance not all men practiced protected sex all the time, the present chapter digs more into causes of these practices, particularly for anal penetration. A lot of those causes have to do with respondents' conceptions of unprotected sex in the context of a stable relationship. Following Blummer (1967), it can be said that people behave towards things based on the meanings they attach to such things. An important dimension of meanings has to do with the emotions people developed toward things and not merely with knowledge. Both meanings and emotions are learned and recreated in the interaction with others as well as through an interpretative process. What people think about things has consequences in their lives. For this reason I am interested in presenting the voice of these men who, having the possibility of wearing condoms, embrace practices that convey high risk for their mutual health.

With this purpose, I basically ask respondents to talk about the last time they did not wear condoms, and to identify whether this occurred after diagnosis. The main idea is to identify the elements behind men's decisions to take risks about their health. Posing this question allowed men to recall situations of risks that were omitted when they answered a more general question of whether they wear condoms after diagnosis. Many men who wear condoms on a frequent basis were able to identify some sexual events in which they did not wear condoms or when they had oral sex with contact to bodily fluids. The chapter recreates those scenarios to understand some elements that trigger risky behavior. Many of those elements have to do with their perception of having unprotected sex with a stable partner: their idea of commitment, their desire to feel closer to their partner, their desire to get temporary relief from everyday cautious behavior, and so on.

Other elements have to do with their perceptions of the illness and the capacity of their bodies to receive the virus (in the case of HIV-negative men) or to stop the progress of any acute infection (in the case of HIV-positive men).

The chapter also digs into whether men consciously or unconsciously look for sero-conversion. With this purpose it explores men's reaction to the hypothetical scenario that sero-conversion occurred in the uninfected partner. A general reaction involves fears of infection (either in HIV-negative and HIV-positive men), although men still report situations of unprotected sex due to the love and trust they have for their partners. Looking unconsciously for infection at some point in the relationship is something reported either in men afraid or not afraid of getting HIV/AIDS. A reason for this is the belief that they have the same destiny as a couple, that sero-conversion is a way to equalize the relationship or to have some sort of certainty about their relationship.

8.2 Last Time Condoms Were Not Used

a) Without Internal Ejaculation: When Discordance is Known at the Start of the Relationship

When asked about the effect of HIV discordance on condom use, all couples that were aware of their discordance shortly after engagement indicate having used condoms most of the time. Nevertheless, when I asked them about the last time they did not wear condoms, they report having experienced different situations of risk after diagnosis. In many cases they engaged in anal penetration without condoms as part of sexual foreplay (three out of nine couples and two out of seven men whose partner was not interviewed). In these cases the penetration without a condom occurred for a few seconds to some minutes to get a sense of what it feels like to be in direct contact with a new partner's skin. During this foreplay, the direction of penetration occurred according to the preference of each partner. But there were also situations in which it occurred in both ways just as a form of experimenting new sensations. During this kind of foreplay, respondents report avoiding internal ejaculation, especially when the HIV-positive partner is playing the insertive role, though this does not occurs much in the reverse

situation. Respondents believe there is a greater risk of infection if HIV-negative men receive their partner's semen than vice versa.

HIV-positive men who play the insertive role in this kind of foreplay without condoms report feeling confident in maintaining control and avoiding internal ejaculation. They report that even when they use condoms they avoid internal ejaculation as a form of reducing the risk of infection. These HIV-positive men argue that they like to play without condoms as a petition of their partner and they see that petition as sign of trust and love. Even if they report that physical pleasure is the same with and without condoms they indicate that by not using them they fantasize about being closer to each other. To this extent, an HIV-positive man talks about his strong feeling of self-control and how he has this practice only with his partner because they trust each other. During the interview he indicates that his partner also penetrates him without condoms and that he would not allow anybody else to do it because he is not sure about the willingness of other people to avoid internal ejaculation:

> *I can penetrate him without a condom and I know that it is very risky, very risky, but I know that I will not ejaculate. It is only about stimulating him, because he likes to be stimulated like that. He says: penetrate me without condoms because I want to feel it. For me, when I am penetrated I cannot say whether he wears a condom or not, but with strangers [. . .] people that I do not trust, or who could suddenly ejaculate in me[. . .] I do not do it (Raymundo, in his late forties)* .

This man, similar to many other HIV-positive men who practice unprotected anal penetration without ejaculation, also reports feeling confident in reducing the risk of transmission because he does not have pre-seminal liquid, (a factor that could increase the risk of transmission). Men in general perceive this lack of pre-seminal liquid as a warranty that infection will not occur.

On the other hand, HIV-negative men that are penetrated in this kind of foreplay report that by controlling themselves and avoiding internal ejaculation the partner is demonstrating their care and affection: the partner is sacrificing his own pleasure in the interest of the respondent's health. Nevertheless, when HIV-negative men play an insertive role without using condoms, neither member of the couple is very concerned

about HIV transmission or other kind of infection (even if there is internal ejaculation). They assume that the risk of becoming infected or passing on any other kind of infection to either partner is very unlikely when uninfected men play an insertive role.

HIV-negative men mention several reasons for not using condoms during this type of sexual foreplay. They report a desire to experience the direct contact with their partners' skin, the need to know what it is like to have raw sex with a person with whom they have always used condoms, and for whom they have developed emotional ties throughout time. After having protected sex all the time, they report that one day they simply felt tired of wearing condoms and abandoned themselves to the heat of the moment. The fears of infection they had while having sex or foreplay with penetration were transformed into excitement associated with danger and prohibition: for HIV-negative men this was a way to cope with a risky situation in which they tried to focus exclusively on the gratifying part of sex. Even if they felt regret afterwards, some of them repeated penetration without condoms, managing the risk as something that increased pleasure. Other times they would also repeat unprotected sex, but time played the opposite role as a form of equality: if they had been penetrated the first time, they penetrated the second time. Jesus is a twenty-five year old uninfected man, in a relationship of eight months, who recreates the times in which he did not use condoms with his partner after a long period of protected sex. He says,

> *it was very exciting to feel that physical and intimate contact that is provided by not wearing condoms. It was very exciting. It feels different when you touch other's penis's skin [. . .] and if you add that to the situation of risk [. . .] well you have many things going on in your head [. . .] You [think that] you don't use condoms due to the direct contact with skin, but when you dig more into it, it is due to an affective relationship that you are forging with each other. When I start generating affective ties, it occurs to me that I want to do it without condoms.*

Another HIV-negative man also indicates being tired of using condom in a relationship that lasted approximately four years. The desire of wanting to know what it felt like not to wear condoms with that particular partner made him penetrate him without condoms for a few moments. Like in previous cases, he withdrew and put a condom on to continue sex with his partner. What makes this case different is that the respondent

reports a certain confidence in not catching the virus because his partner had an undetectable number of viral copies (fewer than fifty copies). When talking to physicians and health personnel, this man was told that chances of being infected through a partner with an undetectable viral load could by very small compared to having sex with an unknown person (about whom he would not know his HIV status). Under these premises some respondents have taken the risk of not wearing condoms, and in some cases, as we will see later, they even have anal penetration or oral sex with ejaculation. Recalling the last time he did not use condoms with his HIV-positive partner, this man says:

> *We were in the bedroom. I think we were sleeping and suddenly I felt horny and started playing and I saw there was a sexual response from my partner. In fact I think it was a conscious decision to penetrate him because I wanted to know how it felt [without a condom]. It was one of those situations in which I thought "I am tired of condoms." That's why I did it and I thought: mmm it feels good and I would like to continue like this, but it is better to get off and put a condom on and then to continue [. . .]But we always tried to use condoms all the time [. . .] When this happened I knew that his viral load was undetectable, which made me calm down compared to my other relationship where the viral load was high (Ricardo, thirty-nine years old).*

Although most of the time foreplay without condoms occurs even after having condoms at hand, not having them facilitates this practice. This happens when people have sex in places other than their own houses, when they were not prepared or thinking about having sex, or when things just occurred spontaneously. In this sense, people need to have in mind that wearing condoms is something that should be enforced all the time, and that only one instance of sex without condoms could cause infection or that it could also bring health problems to the HIV-positive partner.

b) Internal Ejaculation without Condoms: When Discordance is Known within the First Months of the Relationship

In extreme cases couples aware of their discordance since the beginning of their relationship report to engaging in anal penetration without condoms and having internal ejaculation (three out of nine couples and two out of seven men whose partner was not interviewed). With the exception of one couple the rest are different couples than those

who reported anal sex as sexual foreplay in the previous section, which indicates the relatively high prevalence of couples who have practiced unprotected sex (even if only for a few times). This is also true for couples who became aware of their discordance after the beginning of their relationship, but within the first six months of engagement (part of whose analysis is included in this section). In all the cases two factors play an important role: 1) the idea that some HIV-negative partners could potentially be immune to HIV (as mentioned before), and 2) little consideration of the possibility that the health of the HIV-positive partner could be aggravated by not wearing condoms. In the case of HIV-negative partners, having been exposed to the virus multiple times with the current and previous partners, or having had any other STD, makes some men think they will never catch the virus. Constant negative results to the Elisa test make some people more confident about the idea that they will not get it. And if they catch it, they think that it will be part of their destiny, or they treat it as evidence that they already had the virus but it was not visible. Using protection is not the most important concern for these couples.

As mentioned in a previous chapter, there is a couple in which the uninfected partner has had multiple sexual partners since early adolescence (Juan, twenty-four years old). He reports having had unprotected sex with five different men almost every day for many years. He discovered that at least one of these men was HIV-positive and died afterwards. He did not know the HIV status of other partners, but they certainly transmitted other STD´s to him, all of which were treated without major problems. In his current relationship, he still practices unprotected sex on a frequent basis, and he still gets negative results to HIV tests. This respondent and his partner (Oscar, forty-one years old), have talked to the physician about why the results are negative, and they have arrived at the conclusion that maybe this young man is one of those persons that is immune to the HIV. In this particular case, the belief of being immune to HIV is a recent consideration added to their multiple reasons for not wearing condoms. Other considerations that played a role for their initial practices of unprotected sex were Juan's lack of attachment to life and sense of loneliness. As he found in his partner a sense of belonging and a reason to enjoy life, he decided to show his commitment by putting

himself at risk of infection. After all, this was a form of breaking with uncertainties and equalizing the relationship.

Another couple also reports having had internal ejaculation several times in the two years they have been together (Gustavo and Diego, HIV-positive and negative respectively). The constant negative results to HIV tests, in spite of the unprotected sex, make them feel confident that their practices are not risky. After these results, they have reduced their practices of prevention, and they have rescinded into unprotected sex. Although they usually play both roles during protected penetration, only the uninfected partner plays the insertive role when condoms are not used. In this sense, internal ejaculation without condoms has only occurred from the uninfected partner to the infected partner; it has never occurred in the opposite way. Although they consider that this practice still conveys risk of infection and re-infection (based on warnings from their physicians), they assume that the risk is much lower than if the HIV-positive partner played an insertive role without using condoms.

Other factors influencing decisions to have unprotected sex with internal ejaculation are the perception even if it is momentary of being in a relationship that will last for many years. In this situation, respondents develop a sense of trusting their partner and a desire to reinforce their mutual connection, which sometimes is expressed through the idea of not interrupting the spontaneity of sex to put a condom on or by forgetting about risks of infection or reinfection. Just being with their partner is something that makes them feel good, and not wearing a condom gives the sensation of being connected with the other person. Respondents indicate that there are moments during which they do not seem too concerned about infection because they are passing good moments in the relationship, and they assume that whatever they do is fine for the relationship, as they perceive this as strong and long-lasting. Nevertheless, when a problem occurs in the relationship, and they think about the possibility of breaking up, they start having feelings of regret, especially the HIV-negative men. When I asked Diego (HIV-negative) to recreate the last time he did not wear condom with his partner, he said:

> *[. . .] the thing is that once in a while we did it without condoms, already knowing [about our discordance to HIV]. It was something that occurred just suddenly, due to the heat of the moment, the desire for [. . .] We did it,*

and when I finished I experienced a moment of remorse, nervousness. It is as if we realized, as if you wake up and says: fuck [. . .] I did what I knew I should not have done. It was not to blame anyone, but more like [. . .] "the stupid it's me, right." Obviously we both were responsible [. . .][although] I feel that before telling me he was HIV-positive, he was responsible, because he should have taken care of me as he already knew. But when we both already know then [he who takes pleasure is guilty] then not having prevention is a lot of my responsibility. What happens is that in the heat of the moment I do not remember [that he is HIV-positive]. How can I tell you? I live as if he were completely healthy. I literally forget. Then when we are doing it, I say: cool, what a nice feeling that I am with my partner [. . .] and we are doing something. The thing is that sex is not only a physical thing. It is a connection with [. . .] a very nice moment. Then when I am doing it, I do not pay attention; I do not recall [his status]. When we are doing it, it is very pleasant and it is to think how I am enjoying it and what to do so he can enjoy it too. Obviously, after knowing each other for such a long time, you already know what he is going to like, what will make him feel horny, etc. At that moment you are more immerse in what you are doing, without thinking [. . .] it does not reach my mind that the risk is there.

Diego's partner, Gustavo, also thinks that not wearing a condom makes him feel closer to his partner, as if they were more part of the same unit; when not wearing condoms *"I feel inside him and him inside me. Condom is a barrier, although I know I have to use it."* For Gustavo condoms are a barrier in physical and emotional terms. He knows he has to use them, but condoms are more a necessity than something he really likes.

Other HIV-negative respondents also mention that even without condoms, they feel somehow secure and protected because they were having sex with their partners. In their responses the idea of trust is mentioned very often. They associate trust with feeling happy, protected and forgetting the possibility of infection. For this reason some men do not use condoms even if they have them at hand. A young man in a seven months relationship describes a moment during which he penetrated his partner, and they did not think much about what they were doing. They report abandoning themselves to the heat of the moment. Recalling how he was feeling at the moment of having sex and afterwards he says,

> *I believe that [trust] made us go ahead, the trust that we have for each other [. . .] feeling good [with your partner], feeling protected, feeling calm. At the moment it did not occur to me the possibility of infection. But two days later, I realized [what we had done], and I told him that I felt bad because I did not know what was going to happen, whether I would get infected or not. He said "let's wish you did not get infected" (Pablo, twenty-two years old).*

For HIV-positive men not wearing condoms also creates the idea of being loved and accepted by their partners. In this sense, an HIV-positive man refers to the few times he has not used condoms with his partner:

> *It was super-cool. We forgot what I had, and we did it without condoms. It was extremely delicious because it was not the same thing "with" than "without." We enjoyed it a lot. It was an enormous ecstasy because I had never had an orgasm in my life [. . .] I felt like the holy glory. Feeling that he loved me when he was taking me, hugging me and telling me that he loved me [. . .] and doing all that can be done in bed [. . .] I think it has been the best day I have had in my life (Alberto, twenty-five years old).*

In cases like this, not wearing condoms is an exception rather than the norm. For this reason when avoidance of condoms occurs it exacerbates the idea of commitment and momentarily relieves the tension of having to take all precautions. Men in these cases report that having had sex without condoms has increased their physical and emotional satisfaction a lot compared to when they have used condoms. They report this sexual event as natural and less constrained by paying attention to the condom.

c) Unprotected Sex in Couples Knowing their Discordance in the Course of their Relationship

Couples aware of their discordance in the course of their relationship (particularly those between 7 months to several years), report using condoms on a frequent basis after the diagnosis of HIV in one of them. Nevertheless, they have also reported unprotected sex several times despite knowing the risk for infection and re-infection (four out of five couples and one out of five men whose partner was not interviewed). They indicate that not wearing condoms is a form of reducing their problems as a couple and a way to feel

connected again with their partner. In the case of the HIV-negative partner, they also perceived that not using condoms is a form of showing their support to their partners and to tell them "I do not care if I become infected." In this respect, Valentin, an HIV-negative man, indicates that his partner withdrew from all sexual interaction with him after diagnosis:

> *He didn't want to have sex with me, but I wanted to. [Then] he penetrated me, something that he usually doesn't do very often [and he did not wear condoms]. [But]I needed to be with him. We had been experiencing some distance and I needed to feel him. He told me that he could infect me, and I told him that it was not possible [. . .] To me that relationship [without condoms] was totally positive, something that I wanted. I felt as if nothing were going to happen. I abandoned myself to everything. I enjoyed it. Later, remorse and distress came to me.*

Even respondents that have used condoms all the time report having experienced the same feelings of not caring about the infection and being tempted sometimes not to use condoms. An HIV-negative man, for example, says that he reports that during the fifth year of the relationship he thought about not using condoms anymore and getting infected. He never did it, but at the time he visualized such action as a way to tell his partner "*you have my support. This is the way I can tell you that I am not afraid of you" (Alfonso, thirty yeas old).*

HIV-positive men report ambivalent feelings of guilt and reconnection with their partners when condoms are not used. They are aware of the risk of infection for their partners and the potential negative consequences for their own health, but they also experience a situation of closeness and the willingness of the partner to stay with them forever, regardless of the circumstances. For some of the HIV-positive men, it is not so much that they have more pleasure without condoms, but more that they feel that their relationship is again on good terms. This is important for these respondents, especially when not using condoms is suggested by their partners.

I asked an HIV-positive man in his late twenties, Gregorio, whether there was something special about the last time condoms were not used with his partner. He said that it was thrilling because he felt that the relationship started again after a period of

distance during which he was having a lot of problems with his partner. They had stopped having sex because the partner felt betrayed for not having been notified about his partner's sero-status since the beginning of the relationship. When they resumed sex after the HIV disclosure, and, in particular, when they did not wear condoms, the respondent experienced that his partner was part of him again, that a strong sense of togetherness had emerged because his partner was willing to be with him again without any kind of conditions. Feelings of guilt were not absent but at the same time he reassured the strong ties of his relationship. About this he says:

> *I did not feel that different [in terms of physical pleasure] because I have the same sensations with a condom. It was just that after he knew I was HIV-positive, I noticed him [drifting] apart. Then [when we had sex without condoms] it was as if things started again. It was very emotional for me and for him, as if the relationship started again. I thought "this man is mine, he is more mine now. At the same time I felt guilty. [But it was as if] [. . .] we are now together in the same train.*

HIV-positive men indicate that a lack of condom use has occurred with the consent of their partners (seven out of seven men who report unprotected anal sex). They indicate that their partners' desire for committing to the relationship has played an important role. It seems that partners were willing to stop worrying about infection and to show their affection. I asked them to recall their experiences without condom use, and they report that at some point in the relationship, their partners have showed interest in not wearing condoms. Many times this has occurred in the heat of sexual arousal, some other times in a more meditated form. Here are two descriptions pointing to the same thing: partner's willingness to have unprotected sex. One HIV-positive man in a relationship of fifteen years and with four years of being diagnosed recalls,

> *I believe that I penetrated him one time. I ejaculated in him when I was already infected. It was without a condom. I think that he did it to me two or three times: he also ejaculated in me without condoms [. . .] After the news, that I am sero-positive, having sexual relations again was very good, but after having ejaculated without condoms you also have feelings of regret. [When] I ejaculated in him, I said: "you know, I am going to withdraw" [before finishing]. And he said: "no, I want you to do it all. I love you and I do not care" [. . .] when I ejaculated I felt how all my emotions went down (Manuel, thirty-eight years old).*

Another HIV-positive man tells that one month after diagnosis they were engaging in foreplay in bed, and his partner penetrated him without condoms. He did not stop his partner because he thought it was just part of foreplay and that his partner would withdraw quickly. Nevertheless, his partner ejaculated inside him, and no condoms were used at all. When I asked him what his partner said about not wearing condoms, he responded: *"[he said that] he does not care to become infected, that he wants me as I am, he is going to stay with me no matter what" (Enrique, thirty-one years old)*. Although this man reports that unprotected sex only occurred a few times after diagnosis, he also reports that his partner did not want to use condoms for a long time. It was due to the respondent's insistence that they had protected sex. (Now this couple has experienced some physical distance in recent years because respondent refuses to have sex until they know the exact future of their relationship).

Another group of HIV-negative men report not being concerned with becoming infected with HIV, or they did not really perceive that as a personal threat. They do not use condoms most of the time, whether only in sexual foreplay without internal ejaculation or in penetration that includes internal ejaculation. These respondents argue that they are not used to wearing condoms: most of their sexual lives (including with their current partners) have been conducted without any kind of protection, and they are not planning to introduce it now. Shortly after knowing about discordance, they talked about the need to wear condoms, but later they simply did not use them. Some of these respondents report internal ejaculation and some others just anal penetration as a form of foreplay that can last more than a few minutes. These respondents said that not using condoms makes them magnify the idea of pleasure and love for their partner:

To the question of why he does not wear condoms after his partner was diagnosed with HIV, an HIV-negative man in relationship of more than twenty years indicates that it was basically because of the love he has for his partner and the pleasure of sex during which he usually plays an insertive role:

> *To me the illness does not exist, as we have succeeded in many things [together] [. . .] we have to live. At that moment [when we have*

> *unprotected sex] you do not think about the consequences. What is the reason? There is no a special reason. I have not asked that question to myself. We simply haven't never done it [wear condoms consistently]. I haven't asked whether there is a reason or not, but we haven't done it [wear condoms] (Adrian, fifty-three)*

Another HIV-negative man indicates that he does not wear condoms for anal foreplay. In this case, his partner plays the insertive role and he withdraws before ejaculation. Respondent says that it is because of the feelings that he has towards his partner that they do not wear condoms for foreplay with anal penetration. He indicates that his relationship is very satisfactory without using condoms. When I asked him what would happened if he became positive he told me that most likely he would not panic as he has seen that with medicine and a good diet life goes on. He had a previous relationship with a man that like his current partner was HIV-positive, and he learned that being HIV-positive is not synonymous anymore with death. The fact that this man has received negative test, in spite of not wearing condoms, makes him also think that he will not get the virus by performing unprotected sex *(Guillermo, 44 years old)*. In the same regard, Guillermo's partner, Gerardo, thirty-three, indicates that for him it is very meaningful that with such practices Guillermo is putting his own health at risk, which demonstrates Guillermo's affection towards him. Gerardo admits that his partner should not show his love in such a way, but in the end, what they both are doing is valid: *"[not wearing condoms for foreplay] is something that makes them worry, but [such worries] are not something that can stop them from having sex in the moment they want. [My partner] is putting his health at risk and for me that means a lot. It has been a demonstration of the affection he has for me."*

d) Couples Who Have Always Used Condoms.

Contrary to the men of the previous sections, who associated commitment with self-abandonment, other men referred to commitment as a mutual responsibility to avoid infection or re-infection. These men reported a strong commitment to using condoms all the time, independent of the moment in the relationship during which they knew their discordance regarding HIV. In some cases, men learned to care for their own health as

part of caring for the relationship, through a long process of assuming their HIV discordance, attending support groups with other HIV-positive men or having counseling with HIV-AIDS experts. For these men, adopting consistent condom use was not an automatic behavior. Many of them initially thought about not using condoms as they felt it was too late to do, and they automatically assumed that both members of the couples were HIV-positive. Back then they experienced similar feelings reported by men of the previous sections: initially they wanted to express their trust in their partners and their commitment to their relationship through unprotected sex. Later on they learned that being HIV discordant was not an illusion or the result of false negative tests of the uninfected partner. They understood that commitment should not mean that both of them had to be HIV-positive. Instead, they learned that commitment was more about facing their new situation together and to implement safe sex practices all the time.

Examples of this were Alfonso (HIV-negative) and his partner, who had sexual relations without condoms for one year before knowing of their discordance. When Alonso's partner (Marcos), received his HIV-positive status, Alfonso reports entering into a state of confusion when he himself got negative results while his partner was positive. After being tested several times and attending workshops on sexuality, he understood that just because his partner was positive did not mean he had to be positive too. He says, *"after going to psychological counseling, workshops on sexuality and something else […] we saw that mutual support did not mean [some type of] brotherhood, in the sense that 'if you are infected I should also be infected,' but on the contrary: 'if he is infected then all my support should go to him and, above all, to face this new situation"*. He also mentions that after his incredulity about his HIV-negative results, the doctor talked to him and made him realize the importance of remaining uninfected: "*I still remember her words: 'a pact of love is not about both being HIV positive, but about other things. It is based on love, friendship, everything else, except in being HIV positive.' That was a strong [statement] that made me open [my] eyes"*.

For men with a strong conviction about using condoms all the time, protection is not only about avoiding primary infection by passing on the HIV to the uninfected partner, but also about avoiding re-infection which could have possible negative health

consequence for the positive partner. These men are vigilant about possible risky situations, and they try to minimize all of them. They wear condoms all the time, and when these break, they immediately change them, caring for the other. Ramiro, an HIV-negative man, says, for example, *"I think I don't ignore [it] [when condoms break]… He takes care of me and both try to care for the other."* When asked whether in the future they would get tired of wearing condoms and would stop using them, Ramiro categorically gave a negative answer: *"No, I use them and I am very conscious that it is for my security and for his security. It is not only for my [security, so] I am not thinking individually, but it is about our security… He takes care of me, and I take care of him… and I don't regret wearing condoms."*

Like Ramiro, other men saw wearing condoms as a form of mutual protection. Some report being familiar with condom use even before knowing of their discordance, so its reinforcement was not a difficult task. For these men condoms are not a barrier for an intimate connection with their partners. They report being able to dissociate the rational part of a relationship from the emotional and sexual parts, so they feel that in spite of wearing condoms for anal sex they continue having a mutual sexual connection. They agree with the previous group that condom use is a mutual responsibility and will benefit both men. When asked about the factors that facilitated or inhibited the use of condoms, Gabriel, a man who was diagnosed with HIV two years prior to the interview, says, *"We always use it. When for any reasons he is mischievous I am the first person that reminds [him off] its use […] Condoms are my caring for him and from him towards me to avoid infection. . . We have always used them."*

These men also report condom use as a form of mutual protection and report the mutual desire to maintain their health as much as possible. When asked about who suggested condom use after learning of discordance to HIV, an HIV-negative man (Luis) said:

> *"it was not me, it was not him. It came naturally from the information that we had and we knew it was something we had to do. It was to protect each other. At the beginning he expressed it to me: 'I want to protect you.' And I told him: 'Perfect, I accept the protection and vice versa.' Later on I*

realized that it was not that he was protecting me, or that I was protecting him [...] but that we both were protecting each other. That is why I say that with regard to health each one is responsible for his own health [. . .] Both of us [are responsible], because it may be that condom is a barrier, but if I do not take care of myself and I had a different infection from the HIV, then I should take care of him and avoid infecting him and vice versa [...] Something that is not obvious [but] that is there for sure: he takes care of me and I have to take care that he does not infect me with the virus."

8.3 Difference Between Wearing and Not Wearing Condoms

a) Difference in Emotional Connectivity with Partner

To further investigate why people put themselves at risk of primary or secondary infection, I asked all my interviewees if they perceive a difference between wearing and not wearing condoms. Results show that for many men there is not much difference in terms of physical pleasure, regardless of the moment in which couples became aware of their HIV discordance (seventeen out of forty-four men). This group of men says that pleasure is something mental rather than something physical. For them the difference is in emotional terms because not wearing condoms is experienced as showing trust for each other and as an expression that the relationship is on good terms, which makes fears of the virus invisible during sexual interaction. To this extent, an HIV-negative young man in a discordant relationship of seven months compares the last time he did not wear condoms to other times which he did use them: "*To me this time [without condoms] was the same in terms of pleasure, compared to when I use condoms. It was nice but I felt the same. [Nevertheless] emotionally speaking [it] was different: it was nice because both of us did what we wanted and we abandoned ourselves to the trust we have in each other (Pablo, twenty-two years old).*

b) Difference in Physical Pleasure

In contrast with the previous men, there is another group of respondents that strongly thinks that wearing condoms decreases physical pleasure (twenty-one out of forty-four). They experience a lot of excitement due to direct contact with their partners' skin and bodily fluids. On this point, many respondents emphasize that physical pleasure decreases especially for the partner that penetrates and not as much for the one who is penetrated. In all cases these respondents also associate a lack of condom use with emotional closeness. They report a feeling of being alive and together as a cause for not wearing condoms; there is not a piece of plastic between them and their partners. Many of these respondents state that when they develop affectionate ties with a person, they start anticipating not wearing condoms because it manifests that the relationship has been consolidated. In this sense an HIV-positive man indicates that for him condoms affect the sexual relationship:

> *Yes, [wearing condoms] makes sex different in terms of pleasure. Eating a wrapped candy is not tasty. When we do not use condoms I feel that we are more connected to each other. I feel that I am in him and that he is in me. A condom is a barrier and I know I have to use it [. . .] Condoms rubbed me during penetration. I do not like it, because it is too tight. It bothers me. [And] if I penetrate with condoms it is very difficult for me to ejaculate. [If I am penetrated] I do not dislike them, but I also prefer without condoms (Gustavo, thirty-nine years old).*

Both groups of men agree that when condoms are not used, there is a moment of regret afterwards, regardless of their perception of the decline of physical/emotional pleasure. Men indicate that although not wearing a condom creates the idea of deepest involvement and more joy in the relationship, it also produces feelings of guilt and remorse. After not wearing condoms, men experience a certain discomfort regarding their own and their partners' health. In this sense, they state that being in a discordant relationship makes sex a different experience *(Hector, thirty-three years old)*. These men, for example, report fears of infection and re-infection as a new element in their life, a reason for constant tension and for not enjoying sex to the full extent. There are constant thoughts about every possible mistake they have made that could potentially lead them to become HIV-positive.

For other respondents, moreover, the presence of fear is also a challenge they translate into part of the sexual game. Being aware of the potential risk of infection makes sexual interaction more exciting, especially if condoms are not used. When this happens they also maximize the spontaneity that is gained during sexual interaction. Jesus, for example, is a young HIV-negative man in a relationship of eight months. He was aware of his partner's sero-positivity since the beginning of the relationship, and he describes a moment in which condoms were not used:

> *There was only one occasion in which he penetrated me without condom and it was a situation in which [. . .] I don't know [. . .] I think that sex is something visceral in which your head only plays a second role. You abandon yourself and you start to get horny and it suddenly happens that you have sex. And some weird things happen because [. . .] you have fears up front. In my case, as being the HIV-negative part in the couple [. . .] I am in the search of knowing how to manage the virus. That is something funny, because not only the person that is HIV-positive needs to know how to manage the virus and how to cope with the virus that is there. It already happened to me: it was a practice with risk and in this search of managing the virus something interesting happened. I used the possibility of risk as something exciting. At the end I was already there, doing it. You suddenly realized that you were penetrated without a condom. In that moment you feel afraid [. . .] but in my case I feel that it is like a mental trick. Your head lies to you to justify to yourself about the things you are doing. It lies to you in that search of managing the virus. Suddenly then, it is something exciting because is something that you should not do. In other words, we know that we should use condoms because we are a discordant couple and as we did something wrong, it generated in me some peculiar excitement. At the end, it ended up being stormy because later you say: no, no, no, this is wrong and ok [. . .] we were cautions, if it can be named in that way, to have no internal ejaculation because that would have increased the risk of HIV transmission. At the end it was only two minutes in which it happened and all this was in my mind: that it is something exciting, that you are afraid, that you want to stop, that at the same time you are excited and you want to continue. All that is in your mind.*

c) Do not Know about a Difference

A final group of respondents, although very few in number (three out of twenty-one), report having worn condoms all their lives or for a long time (even before awareness of HIV discordance). These interviewees indicate that for them it is practically

impossible to talk about the difference between wearing and not wearing condoms. They have integrated them into their sexual lives, and they have never thought about not using them. For them condoms have neither been a barrier for having sexual pleasure with their partners nor an element that decreases their libido. They have adapted so well to their use that they do not question it at all. When I asked about such difference one man simply said, "*I do not remember how it is to have sexual relations without a condom. I do not know. It has been so many years that I do not remember" (Mario, forty-two years old)*

An HIV-negative young man also mentions not knowing what the difference between wearing and not wearing condoms is. He said, "*I do not remember because it was only one time [that I did not use condoms]. I do not think that there is difference in using or not using condoms when you are penetrated. I think that there is a difference when you penetrate, but I cannot tell you as I have always used condoms" (Alejandro, thirty-two years old).*

8.4 Reaction to a Hypothetical Scenario of HIV infection

To understand why people engage in unprotected sex, in spite of being aware of the risk of HIV transmission or re-infection, I also investigated the interviewees' perception to a hypothetical scenario of primary infection. With this purpose I asked them whether they had considered that possibility and how they would react. The sections that follow illustrate the perceptions of respondents differentiated by HIV status.

a) Perception of HIV-negative Respondents

To a hypothetical scenario of HIV sero-conversion, there are basically two kinds of reactions from HIV-negative respondents. One group expressed being afraid of infection since they knew about their discordance or because they saw the effects of the disease in their partner; a second group expressed their lack of fears to infection due to the current medicine to arrest the effects of disease and the different forms of protection.

a.1) Fears of infection

One group of HIV-negative respondents generally indicated they are very afraid of becoming HIV-positive (thirteen out of twenty-one). The reasons for this varied from individual to individual, but to summarize the most important, respondents indicated that they are afraid of the negative consequences that the virus could cause in their personal and professional lives, as well as the impact on a broader level that the virus could have on other people who are significant in their lives. Men, for example, mentioned that they have thought about the possibility of becoming HIV-positive, and they have concluded that it would be a very depressing process. They are worried about the personal effects of the disease and how it could affect their performance in their professional carriers, as for many of these men their bodies are their main source of work. Many of them are dancers or actors, and changes in their image or lack of energy to perform their work before an audience would have a negative impact: "*I would like to think that my life would be normal [if I became HIV-positive], but as I am a dancer I think that it would affect it a lot. I work with my body and I put my body under constant physical pressure. With the disease my capacity would be affected" (Jesus, twenty-five years).*

Another man afraid of infection expresses his concern for his family and friends, and he also refers to his own incapacity to deal with the disease: *"I have thought about it and I would be depressed a lot. You think about your family, your friends, life is not going to be the same. Before I used to get depressed and I think it would affect me in that way" (Roberto, twenty-six years old).* It is significant that men also referred to the effect their hypothetical infection would cause other people, rather than concentrating on themselves.

Some of these men (six out of thirteen) have been consistent in condom use with their partners, especially after awareness of discordance. Nevertheless, some of them (seven out of thirteen) have experienced some practices of risk: unprotected anal penetration as a form of foreplay referred to before or even accompanied with internal ejaculation. It is interesting that at some point in the relationship these men have expressed that they would not care much about being infected, if they had some warranty

that they would live with their current partners or that they would not be rejected by a potential new partner. It seems that these men could potentially stop wearing condoms if they simply felt a stronger commitment in the relationship: "*I have told him: 'I would not mind [becoming HIV-positive), if I were living with you.' I think that my life would continue being normal, but it would hurt me not to be with him because I would be afraid of being rejected by the person I fell in love with" (Tomas, twenty-four years old).*

Among respondents who show some degree of fear of the disease, there are people that initially did not care much about getting infected (four out of thirteen). They did not know much about the consequences of HIV at the moment of receiving the news. In spite of the shock right after the news of their partners' sero-positivity, they had not yet seen the discrimination that their partners suffered in different places or the need to take medicine everyday. Nevertheless, after a certain amount of time passed they changed their perceptions about the disease, and they report having understood that there is no need that both become HIV-positive. If they want to support their partners in facing HIV, respondents consider it necessary to be healthy and helpful. To this extent a man says, "*I do not know what would happen if I had it [HIV]. Perhaps I would be stressing, but I would have to learn how to live it. I would have to go to therapy. In the first two years I did not mind to be infected, but now I do. I am allergic to medications. I would get mad at him (Valentin, thirty-eight years old).*

a.2) Not Showing Fears of Infection

A final group of HIV-negative respondents indicates they are not afraid of becoming infected with HIV because there are different forms of protection (four out of twenty-one). In spite of these possibilities of infection, these men do not always practice protected sex. Some of them wear condoms only when the partner penetrates them, but not when they penetrate their partner. Other respondents report being penetrated without condoms for short periods of time without internal ejaculation: when the partner is about to ejaculate he withdraws and puts a condom on.

Adrian, a man over fifty years old and in a relationship of more than twenty years, says with respect to the possibility of becoming HIV-positive,

> *I have thought about it and I know the disease. I know perfectly the process and the time we are living. I know my age and [. . .] if it comes, it will come [. . .] I am not afraid, because there are many forms of being careful and protecting ourselves. I have lived it with many other people and because of the times we are living in. I am careful using condoms when he penetrates me and trying not to have affairs.*

This man also reports not wearing condoms when he penetrates his partner under the assumption that the risk of being infected is lower. He also reports avoiding internal ejaculation to prevent any potential health problem.

Other HIV-negative men, who have declared not being afraid of HIV, have also felt the compulsion to show their lack of fears of the disease by not using condoms. This compulsion has also mixed with their need to demonstrate their trust and affection to their partner. Alfonso (thirty years old), for example, reports that when he knew his partner was HIV-positive, it was hard for him to understand that "love" does not imply that both should be positive. He was, unconsciously, looking to become HIV-positive too. At some moments during the relationship he thought about not wearing condoms many times. For Alfonso this was a way to show his trust in the relationship: "*as a blood pact, like to tell him 'I am not afraid of the HIV.'*"

Men not afraid of HIV report that currently medical advances allow people to live longer. They have seen the process of the disease in some friends and in the partner, and they consider that HIV does not necessarily take people to their deaths. Most of these respondents have being engaged for many years with their partners (two, five, nine and twenty years), and they think they will live together for many more years. If they got infected it would be as any other illness, and they expect to remain with their partners and to have a smooth process of understanding and assimilating to the situation. Some respondents think that after many years of unprotected sex, especially before their partners became HIV-positive, they are probably already HIV-positive. For them it is just a matter of time for the virus to become visible or make its presence known on the tests.

Within this group, there are persons that report a certain confidence in not becoming infected. Their results for HIV tests are always negative, even after many years of being in one or two discordant relationships. They perceive the chances for their HIV results to be positive as very small. Some practice anal penetration without condoms only as a form of foreplay, and others also have internal ejaculation. They think they may be immune to HIV and if they became HIV-positive then it would not be the end of their lives:

> *In the first two years I was afraid [of infection] because he has a lot of pre-seminal liquid, but all my tests to Elisa are negative. I believe that the following exams will also be negative [. . .] [And if results were positive] I think that I could not be surprised. I would take it easy, because my previous partner was also HIV-positive and I have been with my current partner for five years. I know that the world is not going to end. It would be like winning the lottery (Guillermo, forty-four years old).*

b) Perception of HIV-positive Respondents

Attitudes toward the possibility of their partners' infection were diverse among HIV-positive respondents. Some men report being afraid of transmitting infection, as they do not want their partners to experience the same situation. With this purpose some men would disclose up front their status to their partner at the beginning of the relationship and look for mutual protection (seven out of thirteen). Other men concealed their status for a period of time before they were sure that partner would show some understanding of the situation (six out of thirteen): until then, most of these men avoided practices of high risk or suggested protected sex. After disclosure of diagnosis, both partners were more careful about protection.

When I asked an HIV-positive man about the possibility of infection he said, "*I would feel bad because I do not know who infected me. It would be as to destroy his life, in the same way as somebody did it to me. I would feel very bad. I do not wish that for anybody. I understand it because he is only twenty one [. . .] [and] I was twenty years old when I was infected. I really felt that somebody destroyed my life" (Sergio, thirty-six years old).* For this reason he says that both have talked about prevention and that his

partner does not give him oral sex and there is not much contact with bodily fluids between them.

In couples that received the HIV diagnosis after a long time of being together, HIV-positive men were extremely frightened about their new situation and did not want to engage in any kind of sex. Worries about infecting the partner and uncertainty about their future reduced their sexual libidos in the first weeks or months after diagnosis. An HIV-positive man in a relationship of more than fifteen years comments that when he was diagnosed with HIV he rejected having a "more complete relationship" because he knew that he could transmit the virus to his partner. Nevertheless they both talked about the possibilities of infection, and his partner told him not to care much about becoming HIV-positive: "*[my partner] has always told me [and] [. . .] has expressed it physically and emotionally, in difficult moments, that he is always with me in everything, and [. . .] we decided to stay together no matter what. He did not care about becoming infected (Manuel, thirty-eight years old).*

Many other men expressed a different perception of the possibility of their partners' infection, regardless of the time they became aware of discordance (seven out of twenty-three). They have learned along with their partners that responsibility for avoiding infection is mutual. They indicate that they should both care for the other and be ready to use protection when having sex. Each one should take responsibility if they decide to have unprotected sex, and each one is aware of the risk they are taking by having any kind of sexual practice. Some of these HIV-positive respondents indicate that for their partners it has been difficult to understand their own responsibility on this matter. In this respect Raymundo, in his late 40's, says, "*For him [my partner] it has been difficult to understand that we both are responsible. My responsibility is to take care of the person and the responsibility of the other person is to take care of the partner. We are adults, and if we decide not to take precautions when having sex it is our mutual responsibility."*

Another man, Gabriel, expresses that both he and his partner have thought about the consequences of unprotected sex for their health. Throughout time the respondent has learned not to feel guilty if infection occurs because he is not forcing his partner to have sex. That is a mutual and consented upon decision:

We have thought about it [infection]. Since the beginning we both went to therapy. The responsibility of being infected with HIV is individual, of only one person. If he gets to be infected it is his responsibility. It is not my responsibility [. . .] I do not have to feel guilty if he gets the infection. It is his responsibility. We are both being careful and if at some point he becomes infected I don't think that it would affect [the relationship] that much.

One particular concern of all HIV-positive men is the possibility that their partner could get infected through casual sex. If this were the case they would not like to assume responsibility for their partners' decision to play around with other men. HIV-positive men are afraid that in such cases their partners could think that other men are not HIV-positive and not be cautious when having sex. This concern was particularly strong in many men who disclosed their status at the start of the relationship. They report not having seen, in many cases, any paper confirming that their partner is HIV-negative. They said that probably their partners are already HIV-positive without knowing it. If that were the case, respondents would not like to be the target of partner's anger and frustration:

I was afraid many times that he could get infected, but I have realized that he has been unfaithful and I am afraid that later he will be sero-positive. It is a big concern for me, because up to the present I have never seen that he has taken a serological test. I told him one time: as far as I know you are negative, but if one day you tell me that you are positive I will not know if I infected you (Raymundo).

In most cases the couples have talked about the possibility of infection, or the topic has come indirectly to the table at some point in the relationship after each member has expressed fears of infection. Nevertheless, those with the strongest fears of infection have not been capable to talk about the possibility of transmission within the couple. HIV-positive men whose partners are very afraid of the virus report that their partners usually do not want to talk and prefer not to think about any possible scenario of infection. When I asked an HIV-positive man whether he and his partner have talked about the possibility of infection he mentioned, "*It would hurt him a lot, but it is something about which he does not like to talk a lot. That is something in which his*

attitude is of we can talk about this but we cannot go beyond. He does not like to talk a lot. His attitude is: I do not know what could happen. We cannot talk" (Alberto, twenty-five years old).

8.5 Conclusions

This chapter deepens our understanding of risky behavior briefly mentioned in the previous chapter and explores new scenarios of risk. It also looks deeply at respondent's perceptions and feelings during such practices of risk. Like previous research (Geringer et al., 1990; Davis, 2002), the present analysis shows that knowledge is not sufficient to stop risky behavior. Meanings that people attach to things also have an important effect on an individual's behavior. In general terms, this chapter shows that the way people have learned to conceptualize their relationship and the performance of unprotected sex are associated with risky behavior. On the one hand there are men who learned that showing support and commitment involved protecting each one from infection or reinfection: to be in good health that would contribute to a better quality of life for both of them. This process was not automatic and it took them some time to understand it, especially after interacting and exchanging experiences with HIV-positive friends and counselors. On the other hand, men who felt that showing commitment to each other was sharing the same destiny and abandoning themselves to the heat of the moment reported events of unprotected sex. The chapter presents a variety of situations that are summarized in the following paragraphs.

The analysis starts by asking respondents about the last time they did not wear condoms. This question allowed respondents to recreate several situations of risk that they had previously omitted because they did not consider them very important. Many participants had previously mentioned wearing condoms all the time, especially after one of them was diagnosed with HIV. When making such statements they basically referred to wearing condoms for anal penetration when ejaculation was present. But they did not consider situations in which they still practiced anal penetration without condoms and withdrew before ejaculation. This practice, although not frequently observed in all

couples, was experienced by many of them. Respondents started this practice as a spontaneous part of sexual foreplay during which they simply wanted to feel their partners' skin. This phenomenon was especially important in couples who had never had anal intercourse without condoms or had used condoms for a long time, so they were wondering what it was like to have raw sex with their partners. Some men reported these practices only a couple of times; others had them as part of their everyday sexual lives. Initially they all had fears about the negative consequences for their health, but after taking HIV tests or noticing no changes in their health, they continued repeating this practice. They report that if there is not semen the risk of infection is very low, and practically all of them were confident about not having pre-ejaculatory fluids, particularly men who were HIV-positive. Whether men can really avoid the exchange of bodily fluids through this practice is something that can be questioned. It is likely that this practice can potentially become a risk factor for new infections among this population or become the source of other infections for HIV-positive men.

Other men reported not wearing condoms with internal ejaculation at least a couple of times, if not on a daily basis (fifteen out of forty-four). Their testimonies are important because they help us to understand circumstances in which people are willing and sometimes looking for unprotected sex. In this group there are men who had been together for a long time before one of them was diagnosed with HIV, but it also includes men who had just met and were discordant since the beginning of their relationship. As with those who only practiced unprotected anal penetration as a form of sexual foreplay, one factor influencing practicing internal ejaculation without condoms was the desire to feel closer to the partner. Expressing mutual commitment and visualizing their relationship as something permanent made these men take risks involving infection or re-infection. They perceive that if their current partner was the man they were looking for a long time ago, it was worth it to take certain risks. These men believed that partnership is about having a common destiny. For them equalizing their relationship in terms of HIV was a form of achieving a certain harmony.

A lot of these couples were not looking for sero-conversion. Nevertheless, being with a person they trust and for whom they had feelings for led them to forget about the

illness during the heat of sexual passion. At that moment they were only concerned with having a good time together. For these men being happy provided a temporary illusion of protection, even if this was transformed into remorse afterwards. Not wearing condoms provided temporary relief from the everyday compulsion of having to be careful all the time.

The idea of being immune to HIV is also another factor that leads some couples to have unprotected sex. In these cases, the uninfected partner has repeatedly received negative results to the Elisa test, in spite of many risky situations in which they have been involved, sometimes not only in the current relationship. Negative results and a partner's undetectable viral load increase confidence that no infection will occur in spite of unprotected sex. In addition, these men usually don't worry much about the possible effects have sex on the infected partner, as his immunological system also presents high levels of CD4 cell counts for a long time. They report that if the health of each one of them were affected for having unprotected sex, they would assume it as part of their relationship.

When investigating their perceived difference between wearing and not wearing a condom, a lot of men talked about the reduction of physical pleasure when using them (twenty-one out of forty-four). This was an important factor for having raw sex. Nevertheless, there were also men for whom condoms do not reduce physical pleasure and who still do not use them consistently (ten out of seventeen). They argue that they do not use condoms because of its potential effect on the relationship, rather than the "real" physical pleasure it could provide. Not wearing condoms is a form of reconnecting with the partner after serious problems in the relationship. It is a way for both parties to show their commitment to the relationship, a way to express that they want to continue, and that their discordance is not an issue that would prevent them from being together. In cases where HIV in one partner was diagnosed after a long time of being together, reconnecting with the partner through raw sex was important because raw sex minimized the feelings of rancor and distance that the virus initially brought into the relationship.

To summarize, basically all couples had fears of the potential negative consequences for their health due to raw sex. Nevertheless, the way they conceptualized

their relationships led some men to either seek or not seek protected sex. Some men learned, after a long process of coping with the virus, that commitment was not about looking for sero-conversion, but about both of them being healthy. To support each other they both needed to be in good health conditions: the HIV-negative partner remaining uninfected and the HIV-positive partner avoiding other possible diseases. On the other hand, men who understood commitment as showing no fears of health problems practiced raw sex as a consequence, even if only a couple of times. In some of these cases, HIV-negative men indicated that they went through a mental process in which they transformed their fears of infection into feelings of excitement associated with the danger of their practice. This was a game they had to use as their own form to cope with the virus. HIV-positive men, in the same situation, reported that responsibilities for protection or infection were mutual, and as they did not have sex against anyone's will, each one had to assume their own part for the potential negative consequences for their health.

Chapter 9: Meanings Attached to Sex

9.1 Introduction

This chapter explores the perception of men about sexual interaction in the context of their current relationship. From the basic question of how important sex is in the current relationship the chapter explores the different connotations that men give to sex. It first starts with a general view on the topic and latter progresses to focus particularly on anal penetration, a practice that carries a high risk of HIV transmission. The chapter also presents men's perception about semen and men's direct contact with bodily fluids. This information is important because it helps to understand different factors or motivators for men to engage in risky sex, sometimes willingly and some other times unwillingly. By giving answer to the previous questions the present chapter follows the premise that if people think things as real, these are real in their consequences (Thomas and Thomas, 1928). In other words, people behave toward things based on the meanings that things have for them (Blumer, 1969). Such meanings are created/re-created collectively through face-to-face interaction, and individuals interpret and transform them based on their own experience. The conclusions will show that interviewees perceive sexual interaction as an important dimension that keeps the relationship on good terms, which in some instances includes direct contact with bodily fluids. Such perceptions are not monolithic, and they change throughout age and time in the relationship. They are also associated with meanings attached to duties and rights within a relationship, which in turn depend on the position of each member within the relationship, especially in cases in which respondents depend on their partners economically.

9.2 Meaning of Sex in the context of the Partnership

Different dimensions were present in interviewees' perception of sexual activity in the context of a stable relationship: these were physical, emotional and material

dimensions. Such dimensions are not opposite to one another, they were all mixed in respondents' perception. Here these dimensions are separated only for presentation purposes. My interviewees highlighted one or more of these dimensions depending on their age, duration of the relationship and position within the relationship.

a) Physical/Emotional

When asked about their definition or perception of sex, couples referred at least to two levels of conceptualizations: the physical and the emotional. They defined sex as a physical act that involves a variety of practices that include, but are not limited to: kissing, hugging, touching, performing or receiving oral sex or anal penetration, as well as mutual masturbation. These practices are related to pure physical gratification. Nevertheless, in the context of their relationship, respondents expressed that such practices are also accompanied with an intention to share and to amalgamate different feelings and inherent parts of what they are as individuals. In this sense, respondents visualize sex as a physical need that is closely connected to the idea of affection: they talk about sexual gratification and emotional needs as two indissoluble things that form human nature. Sex is not only about feeling good or making their partner feel good, but also about amalgamating emotions and sensations with the person with whom they are involved. When asked about this matter, Tomas, an HIV-negative man in his early twenties, indicated that sex *"is not only [the act of] penetrating and coming to a climax, but about producing sensations in [the] partner that not even he can produce. [Sex] is [the act of] joining together in sensations and emotions that nobody else can give you."*

Men indicated they have sex with their partner for love, mutual care and continuous understanding. With sex they reach an emotional connection with the partner unlike their connection with any other person. They state that having sex with the partner is a way to express affection, something they can perceive because of the way that touching and caressing take form. Respondents say that this is different with persons they do not love or they do not feel affection for. In the first case, the kind of intimacy they reach does not correspond to their public lives, but to a more private and intimate life that

nobody else can enter or have access to. It corresponds to the respondent's private world, to a world in which only the respondent and his partner are merged.

Diego, an HIV-negative respondent in his early thirties, indicated that the most important reason for having sex with his partner was affection. He said:

> *there are moments in which sex is done simply for [the sake of it] and is something good in a physical sense, but there are moments too in which we come to a climax together, and it has been nice, it has been that connection [between the two of us]. Sex is then another form of connecting to each other [. . .] and that would be like the first [reason for having sex with him]. I do not discard the physical part because everybody gets horny and when it happens [. . .][it] is nice to be able to satisfy [that part]. We are compatible in sex. He knows how to excite me and please me, while other persons have not been able to do that, and vice versa. I believe that we have reached a physical and emotional compatibility, being the emotional the most important one.*

Those two elements, physical pleasure and emotional intimacy, were present when respondents were asked about their particular reason for having sex with their current partners. Depending on their age, respondents would stress one element more than the other, but they would always include both elements in their perception of sex. Respondents in their twenties or early thirties, for example, emphasized more than older respondents that their sexual urges were due to their age as one reason for having sex. For them sex was fun and exciting, and having sex with their partners was particularly special for the affection involved. But they report getting easily excited and to potentially looking for sex with someone else if they had no sex with their partners. They also report that their partners demanded sex from them, and if there was no sex activity problems in the relationship would arise.

b) Companionship

Respondents also indicate that as time passes, sex is understood more as companionship, rather than as mere physical contact that has to end in ejaculation. With age, the physical part of sex is left behind and is simply perceived as another ingredient in the relationship. In this situation, sex is understood as an expression of their relationship, but not the most important part. For example, a man in his late thirties, with

college education, states that after fifteen years of his relationship, he learned that sexuality is not to have explicit sex with somebody, but to be with that person, to enjoy him, to touch him, to kiss him, without them both necessarily having to reach ejaculation. Before, when he was younger, he considered that if there was no ejaculation, there was no sex (Valentin, thirty-eight years old). In the same sense, another man in his late thirties said that sexuality for him is still pleasant, but with age the physical part of the relationship has decreased in importance and now companionship is more relevant (Ricardo, thirty-nine years old).

Many expressed that sex was equally important in their lives as other things like eating, breathing, being together, and so on, but then again they connected the pleasure that sex provides by itself with the idea of companionship. In the words of one respondent,

> *[Sex] is important like being together, like taking care of each other. It is important like providing company to the other. It is one thing among many other important things. Having sexual relationships is good, pleasant, is noble, because you are sympathizing with the other person. You are also providing company to your self [sympathizing] (Mario, forty-two years).*

c) Abandoning Oneself to Another

In respondents' definition of sex there is a constant perception of sex as allowing them to abandon themselves to their partners in terms of pleasure and affection regardless of age, time of engagement, and education. Respondents indicate that from sex they expect to give and receive without limitation as a way to reach what they call physical and spiritual climax. To this extent an HIV-negative man in his late twenties and in a relationship of five months, says that "*sex could be 'an encounter of two persons that can be the climax of love [. . .] or a mutual agreement to satisfy a physical need. [But] for me it is total abandonment in the physical and emotional sense'" (Ramiro, twenty-nine years old).* He adds to this statements that some of the reasons for having sex with his actual partner are affection, mutual understanding and to give and receive equally from his partner.

Another man, HIV-positive, also expresses the idea of sex as an act of abandoning himself without limitations. At the same time, he refers to sex as fundamental to keeping his relationship alive:

> *It is to give myself to a person without any restriction, without anything in between. I like for example, to see the person, enjoy him, feel him, and that he feels me. Kissing for me is something exquisite and a lot of times kissing fulfills me totally [. . .] We do not have sex against our will. Nothing happens if there is no sex, but sex is part of our relationship and it keeps it on. If there were no sex things would be cold, so sex helps us to keep the fire on. It is important (Raymundo).*

Abandoning oneself to a partner is then understood as one consequence of the human need for being with somebody or to share intimacy. It implies, under such a definition, physical and spiritual contact that allows feeling connected to the world and that it is expressed through touching, oral sex or penetration. Especially in young men or couples of recent formation, such abandonment is culminated through ejaculation of both partners. For them it is not completed without ejaculation.

d) Sex as a Contract/Emotional Ties

The idea of engagement as a contract with obligations and rights was also another factor for having sex with the partner. Lack of sex was, in many cases (twenty-five out of forty-four), a reason for conflict within the couple. This was true of both partners. As will be mentioned later, some HIV-positive men whose libido decreased due to the use of anti-retroviral faced problems within the couple for their lack of interest in sex. This was also true if the reason for not having sex was fear of infecting the partner right after discovering their HIV status. Supporting this idea, HIV-negative men indicate feeling rejected when their HIV-positive partners did not want to have sex for fears of infecting them. HIV-negative men express that, in spite of their own fears of infection, eliminating sexual activity completely from their lives was not an option. They describe sexual relations as part of a couple's duties. Not having sexual relations was like missing something essential to being committed with another person. This is especially true in couples with many years of living together and who became accustomed to each other.

Some HIV-negative respondents complained about their partners' stubbornness for not understanding that condom use is a form of preventing infection. Similarly, they complained when their partners show no interest in gaining knowledge about protected sex through attending workshops and actively looking for advice from experts. Respondents believed that their partners' attitude was diminishing their relationship. About this topic a respondent, an HIV-negative man, indicates: *"[My partner's reaction] was to go away from my life, something that it is no fair [. . .] He did not want to have sexual contact anymore. I then told him 'we have to learn to use condoms, we have to be careful when having sex [. . .] or we simply have to learn how to do it, to go to courses,' but he is very close-minded. He hasn't wanted to take any courses."* The previous words come from Joaquin, a forty-three year old man engaged for fifteen years with his partner. In the interview he reports having fears of infection, but he also says that stopping sexual relations with his partner was not the solution. He instead showed interest to look for alternatives to resume sexual life and to obtain sexual gratification within the current relationship.

The idea of sex as a contract was also evident when some HIV-negative men felt compelled to have sex to show support for their partner and to show they were not afraid of their partners' sero-status. These respondents wanted to make their partners feel good by not showing signs of rejection. They felt that their partners needed affection because of their HIV-positive condition, so many times in spite of being afraid of infection, respondents would get involved in sexual relations. In some of these situations HIV-negative men report that their partners would not necessarily initiate sexual interaction, but their own perception of their partners' need for affection would make them show a certain disposition for sex. HIV-negative respondents, for example, indicate that after hugging and kissing they would ask their HIV-positive partners if they wanted to have anal penetration, and when the partners gave an affirmative answer, respondents felt compelled to accept: after all, how could the respondents deny anal sex if they were the ones who posed the question. To the question of whether he feels compelled to have show his affection through sex, a man in a relationship of six months indicates: "*Yes, of course. I feel that he needs that I give him that affection. I feel the need, even without*

having sexual desire or having fears [of infection], I feel that I need to show him that I love him and that I am with him and to show him that I am not afraid of the situation (Alejandro, twenty-seven years old).

e) Contract/Economic Ties

Having sex to compensate for the economic support received from the partner seemed to be another factor influencing sexual interaction in the context of stable relationship (eight out of forty-four). Usually these HIV-negative respondents were much younger than their partners, and they expressed that sex was a way to fulfill their role as partners, juxtaposed with their own needs for companionship and sexual pleasure. Having a need for economic support, these respondents probably had fulfilled their expressed sense of loneliness and sexual needs with another person. They indicate that sex with their partners was okay, but it was neither explosive nor a full expression of love. Respondents said that it was mostly that they were young and needed somebody with whom to share time and companionship. It seems that the economic support received was also a plus that affected the interaction with the partner.

Respondents realized that whenever they rejected having sex with the partner, problems in the relationship emerged. To avoid such difficulties and because of their economic dependence on their partners, respondents consented to having sex without necessarily being interested in having it with their partner all the time. When asked what happened when he did not want to have sex, Pedro, a twenty-one year old HIV-negative man said,

> *he [my partner] gets mad, sometimes with reason and sometimes without reason, because unfortunately [sex] becomes a routine and in certain cases it is even an obligation [. . .] When there is distance between the two of us I react very badly, because I cry a lot, I am very sentimental. I am used to having a life with him [. . .] and when [he gets mad] I feel bad, because I feel I am extra in this house, I feel displaced, I feel incomplete [. . .] because then it is not anymore the same treatment that I am used to receiving from him. And I feel bad, because sometimes I say: next time even if I do not want it is better to have sex with him to have the relationship in good terms. It is better to avoid distance just because [. . .] I did not want to have sex with him.*

In the same sense, another respondent whose partner died because of AIDS refers to his relationship in which he was aware of HIV discordance at the time. During the interview, the respondent expressed that he was not totally in love with his partner, and when I asked him why he had sex with him, the respondent indicated that it was *"because he was my partner. It was a form to fulfill my obligations. He was kind with me and he helped me economically speaking. Emotionally he also fulfilled a space in my life. It was also for my sexual urges" (Miguel, thirty-seven years old)*. The respondent was twenty-two years at the time of initiating that relationship and his partner was twenty-nine. They were together as couple during five years, after which they broke up. The respondent became HIV-positive a time after partner died, most probably due to casual sex.

f) When Antiretroviral Decreases Sexual Libido

For a few HIV-positive men, sex is not as important as it was before. Due to the use of anti-retroviral their sexual libido has decreased and consequently their interest in having sex (two cases). In this sense, the presence of HIV has indirectly changed their own opinion of and desire for sex, making respondents not so willing to have sexual interaction. They report being in a stage of their lives during which sex is not very important, and they need to redefine their current relationship. This perception does not always correspond, nevertheless, with their partners' opinion, for whom sex might still be a fundamental dimension that keeps things going in the relationship. Such discordance in sexual interest causes, in some cases, problems with the partner. A man in his thirties indicates that when he started taking antiretroviral, having sexual relations with his partner stopped being a priority. His sexual libido decreased substantially. He has talked about this with his partner, stressing his desire to be in good health before resuming sexual interaction, which has caused him a lot of problems in his relationship. His partner, for example, considers the respondent's attitude as egotistic by not taking the partner's needs into account. At the moment of the interview this couple was at an impasse trying to decide the future of their relationship (Enrique, thirty-one years old).

In most other cases, the use of anti-retroviral has not produced any change in the sexual libido of HIV-positive men, or it has increased it. For these men, sex continues to be something essential to their lives and an important dimension that they expect to be present in their relationship. With the exception of an initial interruption of sexual activity after being diagnosed with HIV, they now have the same frequency of sex as they had before the diagnosis or before the presence of symptoms.

9.3 What would happen if there were no sexual relations?

Although most respondents state that sex is not the most important dimension of the relationship, they expressed that lack of sex causes or is caused by problems in the couple, generating distance between partners. The great majority of respondents, regardless of HIV status, especially those in not very long-term relationships, report that if there were no sex anymore, the relationship would probably start cooling down and they would have to find sex with some other person, leading the relationship to break up. In the best of cases, the relationship would turn from a romantic engagement into friendship. Without sexual relations the base for the relationship and mutual connection would disappear. To this extent an HIV-negative respondent said, *"[If there was not sex] our relationship would be a total failure, because we would not be able to merge our worlds"(Jose, thirty-three years old).*

An HIV-negative man in his early thirties, with two years of engagement in the relationship, indicates that in any kind of relationship partners can talk and share experiences and many things, but the presence of sex makes them closer to each other. According to this man, if there is no sex on a frequent basis people can lose interest in the relationship: *"If it is not with [him] maybe [you will have sex] with somebody else. In the long run, I believe that [the relationship] could finish or would turn into friendship (Diego, thirty-two years old).* Along the same lines, another young man reports that if he did not have sexual relations with his partner anymore, they would distance from each other because sex had already become part of the relationship *(Pedro, twenty-one years old).*

Men also report that without sex their relationship would most likely end because it would make them think that somebody else was taking their place, leading to feelings of jealousy and displacement. For respondents, the absence of sex would be a sign of the relationship's deterioration and a reason to break up. These men think that sexuality needs to be satisfied, preferably in the context of a relationship, but if they cannot get satisfied with their current partner, they would look for a new lover. When asked what would happen if there were no sex anymore in their current relationship, an HIV-positive man in his mid thirties indicated,

> *I think that [the relationship] would break, because in spite [of the fact] that supposedly we are friends, we are roommates and buddies in everything that is sexual and everything else[. . .] And I believe that if there were no sex, I would feel displaced and I would have feelings of jealousy [. . .] I know myself and [the relationship] would not work, we would not be together [. . .] well maybe we would continue together but him in his room and I in my own room [. . .] so there would be a very notorious distance between both of us (Sergio, thirty-six years old).*

Another two young HIV-positive men also responded that the relationship would break if there were no sex anymore with their current partner because sex is by definition an important dimension of a relationship. The first respondent is in his late twenties and is in a relationship of two and a half years. He says, "*[without sex] I become hysterical. I would feel very bad, because I get mad. I become neurotic. I think that [. . .] I need to be having sex (andar poniendole). I think that I would leave him and I would look for another person" (Gregorio, twenty-eight years old).* The second man is in his early thirties, and he has five years in his relationship. His comments regard not having sex with his partner are as follows: "*Obviously, I would have [sex] with another person. I think that the relationship would finish, because sex is part of the relationship [. . .] and without it, the relationship would not work anymore. The relationship would be considered over" (Gerardo, thirty-three years old).*

For many respondents in long-term relationships a lack of sex would not necessarily be a factor leading to a break up (ten out of nineteen). They report not being young anymore and having lived together for a long period of time, which has strengthened their bonds. They mention that if affection and commitment is still present

the relationship would continue, even without sex, although it could cool the relationship down a little bit. If neither affection nor sex are present, then the relationship would end. An HIV-negative man in his early fifties with an HIV-positive partner in his late forties, for example, indicates that after twenty years of living together, sex is not very important on a frequent basis because their libidos have decreased. The relationship now consists of affection, support, caresses, and friendship, and only when the hormones wake up do they have sexual relations. But as long as there is still affection for each other and mutual interest, the relationship would continue: "*if there is no sex anymore due to health problems, obviously our relationship would not end, but if there is not sex at all due to another causes, like total lack of desire for your partner, then there will be nothing to do. Each one [will have to live] in his own house" (Adrian, fifty-three years old).*

Another two men in a long term relationship also indicate that after many years living together, their relationship is consolidated, so lack of sex would not affect their relationship drastically, as long as they still had something to share. One of these men talked about his relationship of fourteen years, where in the last five months he was diagnosed with HIV: "*[sex] is a compliment, but as a couple I think that what keeps us together is more the mutual loyalty and the many years living together [. . .] [Without sex] I think that the relationship would cool down a little bit, although there is affection. [But] I do not think that it would finish" (Ismael, thirty-five years old).* In the same sense, a man in a relationship of eight years and with two years of being HIV-positive indicates that nothing would happen if they had no sex anymore; their relationship would still continue if other elements like mutual understanding were still present: *"We have now a very strong tie of friendship, companionship, love and mutual support. I think it would not affect us [if there were no sex]. If we talked about it openly, I do not think that it would be any problem [the lack of sex] (Gabriel, thirty-four years old).*

Another respondent in his early forties mentions that if his partner did not want to have sex with him or vice versa, each one would try to find physical pleasure with somebody else, but the relationship most likely would continue. He gives as a reason that they are really happy living together as a couple. He states that he is deeply involved with his current partner and that he has become very accustomed to him. They already know

each other well, and they already have a routine together to which they have adapted. To start a new relationship just to see what would happen is not something he is contemplating When I asked him what would happen with the relationship if there were no sex anymore, he answered:

> *It would probably continue, because we are happy living together [. . .] if he got emotionally involved and fell in love [with another person] and everything, he probably would leave and I would probably too. But for me it would be very difficult to leave him. Even if I were deeply in love with another person, and that person told me "come with me," that person would have to have many [. . .] exceed many characteristics that my current partner has. I love my current partner a lot and we have already gotten used to each other. In addition to the fact that we deeply love each other, we also got used to each other. I already know the way he is, and he knows the way I am. We have a routine in our relationship and it is a routine that we like. To start again with another person would also be nice [. . .] well in the event that [if my current partner] died. Then I would like to start again with somebody, but I do not need [now], no [. . .] I think only in that way [I would start with somebody again]. Otherwise I am not interested to start a new relationship. I am happy with my current partner (Mario, forty-two years old).*

This man also reports that since the beginning of their relationship sexual interaction was fundamentally based on touching, kissing and mutual masturbation. Anal penetration was never an indispensable part of their practices, which helps to understand why a total absence of sex would not have a strong impact in their relationship.

9.4 Importance of Anal Penetration

I asked men how important anal sex is for their relationship, because this practice carries a high risk of HIV transmission and secondary infection. Even with condoms this practice is not totally exempt from risks. In addition, public health campaigns have relied on the message of alternative sexual practices that do not include anal penetration. Inquiring about the relevance of anal penetration in the context of a relationship allows observing to what extent men are willing to reduce such practice in favor of others of less risk. During the interview practically all respondents said that it is not the most important

practice because there are some other practices full of affection and care that really matter. For respondents, being together and having mutual connection are fundamental parts of their relationships. Nevertheless, throughout the interviews, most respondents reveal that anal penetration has a strong presence in their sexual lives. This practice is not conceived as the only way to have sex, but respondents surely refer to it as part of the "sexual menu." It is something that respondents like to do, if not always, at least on a regular basis.

a) Couples of Recent Formation

Younger respondents, usually in their twenties, refer to their sexual needs as a reason to seek this practice. For many of these respondents, lack of anal sex would be a factor to break up their current relationship. In contrast, respondents in their late thirties or older express that with time they have learned other forms of sexual gratification, like kisses and caresses, and that anal sex does not have to be present all the time. For these respondents, the basis of their relationship would depend more on the existence of developed ties of companionship, rather than the kind of sexual practices they have, although they also indicate that once in a while anal sex is a practice they also desire. Very few people report that a total absence of anal sex would not have much effect on their current relationship at all.

Time of engagement also affects the perception of need for anal sex. For couples of recent formation, especially in combination with young ages, anal sex is perceived as keeping the relationship going on and helping to create attachment with the partner. Within couples who, in addition, became aware of HIV discordance shortly after their formation, respondents indicate that not having anal sex did not matter much initially. Fears of infection were a factor commonly present in these newly formed couples that made respondents of both sero-statuses not to push for anal penetration, at least right after knowing about their discordance. There was a period of time that both members of the couple took to assimilate to their discordance to HIV. During this period they looked for information, and they avoided risky practices, including anal sex. Nevertheless, as time passed by, total absence of anal sex caused the relationship to deteriorate to a great

extent. Dissatisfaction is expressed by respondents who, after certain time, look for anal sex with a different person than the partner. HIV-negative respondents also indicate that their partner also becomes angry and feels rejected because of not having anal sex. Roberto, a respondent in his mid twenties, dating an HIV-positive man (transgender) for eight months, indicates that he was informed by his partner about his HIV status at the beginning of the relationship, and they avoided anal penetration. At the beginning they did not have problems, but at the time of the interview, the respondent considers that this prolonged situation has brought up a lot of problems with his current partner, showing that after all, anal penetration needs to be present in their relationship. Without penetration, some respondents do not consider to have experienced sex in its totality:

> *[Anal sex] is very complementary and not having [anal sex] has deteriorated the relationship a lot. At the beginning I did not care, but with time I realized it is important. For my partner it is important too, but I am afraid of infection. With time you realize that you need full sexual relations with your partner. At the beginning, I did not care, but now with time I realize that [anal sex] is very important. We have talked about that and to tell the truth, I am still very afraid of having sexual relations with her because of her disease. I know that there are methods of prevention and everything, but even with that you have in mind that you can become infected in any moment and it is scary. Then I think that [the lack of anal sex] has deteriorated the relationship a lot. The relationship has been up and down a lot due to this sexual issue. I already told her that [anal penetration] is not the most important thing for me. I feel that in a sexual relationship there are things more important than sex, but sex is very complementary and that is the part that we have not been able to have and I think that because of that we have had many problems in the couple. [For her, the sexual part of our relationship is not plain/full/complete] because there has not been anal penetration. We have always had masturbation and oral sex [. . .] and I think it also requires penetration. For that reason, I think she does not feel totally happy with me in sexual terms (Roberto, twenty-six years old).*

In many couples of recent formation, sexual interaction is a very important factor in keeping together the couple (nine out of twenty-five men). These men are exploring all forms of sexual expression, and many consider anal penetration as something they do not want to miss. As their emotional bonds are in a process of consolidation, they express uncertainty about the future of their relationship if there were not anal penetration at all.

They consider that if they had more time together or their emotional ties were stronger, the kind of sexual practices they had would probably be less important, but given the period of the relationship in which they are, or their young age, when that is the case, they consider anal penetration as an important need. At the current stage of their relationship, not having anal penetration could create problems for a relationship's permanence. Jesus, twenty-five years old and in a relationship of eight months with an HIV-positive man, says:

> *[Anal sex] is very important for me. I think it is also important for him. It is something basic [laughing]. [If there were no anal sex anymore] it would be a problem because we would have to find a substitute to that regard. I think it depends on what we have in mind. Everybody has something different in mind, but for me anal penetration in both ways is very important. There are times in which I feel like to penetrate and times in which I would like to be penetrated [. . .] and if we did not have [anal penetration], it would generate a very difficult situation from my point of view. In my case it would generate a search for another sexual partner, that is to say, if I can not have it with my partner because he does not want or he can't [. . .] it would generate the search for another sexual partner to have the sexual practices that [I like] [. . .] [Whether the relationship would end] I do not know the answer. I do not know, because that would depend on the moment in which it happened. Maybe if it happened in this moment [eight months of relationship], maybe it would finish. But maybe if that situation occurs one year from now my reaction would be different, because I would have generated other types of affective ties with the person [. . .] (But) if in this moments it is decided not to have [anal sex] anymore[. . .] I do not know what would happen. May be we would have to buy a good size dildo [to continue the relationship] [Laughs].*

Men like Jesus describe themselves as very sexual and do not imagine their current relationship without having anal penetration. If they did not have anal penetration they would look for it somewhere else, and they would probably end their current relationship. Other HIV-positive men, although in their forties, also report anal penetration as an important part of the relationship. In these cases the emphasis is not as much on personal sexual urges, but on perceiving anal sex as an intrinsic part of a relationship and experiencing feelings of rejection if a partner did not want to have such a practice with them. For these men, if there is no anal sex there must be a reason for that. They think that a total absence of anal sex is an expression of a deteriorated relationship

and they would most likely break up if partner did not consent such practices. In fact, this has been the case for one man who reports not having anal penetration for a long time with his current relationship. He has proposed to split and look for a new partner, but his current partner says they can continue living together without the need for sexual activity. For his partner, caring and sharing other things is more important, but the HIV-positive respondent wonders if his partner is cheating on him with other men. For this HIV-positive man, the current situation of the relationship is bringing him enormous frustration in his sexual life, and he feels that his needs are not being taken into account. Due to the lack of sexual activity with his partner, he has decided to have lovers that he visits on a frequent basis, but with whom there is no emotional connection. He is not sure whether or how long they will continue together as a couple. (Whether his partner wants to continue living together because he depends on their house and other commodities from his HIV-positive partner is an issue that can be raised).

b) Couples in Long-Term Relationships

In couples of a long duration, respondents report that with time their sexual needs have decreased as a natural process of the relationship, in which it is experienced as a reduction of sexual passion. This is accompanied with a process of aging where sexual libido also decreases with time. These couples report that after many years together desire for sex is not as important as it was at the beginning of the relationship. Now the grounds of the relationship are based on other factors. In that sense, anal sex is not a primordial need in the current state of their relationship. Respondents believe that due to a common history of events with their partner throughout time, the relationship would probably remain without frequent sex as before. Anal sex, nevertheless, is something they would not like to be totally absent from their lives. Luis, a man in his 40´s living for 7 years with his HIV partners says, for example,

> *[Anal penetration] is not very important. I think that [. . .] is part of [the relationship], but it is not necessary. I think that [the things that are important] are the caress, the kisses, the hugs, exploring your partner's body and vice versa, let him explore you. Neither oral sex nor masturbation is necessary or exclusive. I believe [that what matters] is everything. At least for me it is not very important. This is what I have*

learned. Before we had that concept: if there is no penetration, there is no sexual relation [. . .] With age and experience you discover other situations, other emotions, other sensations of a hug and or caress [. . .] and we have learned that sometimes if we just hug, we can end up, in vulgar terms, ejaculating. Then I think that penetration is not necessary.

In spite of that anal penetration is not the fundamental part of sex in long term relationships and/or when respondents are not very young, there is uncertainty about the future of the relationship if there were a total absence of this practice. Men are not totally sure if they could continue together or if the partner would agree with their response. When I asked what would happen if he did not have anal sex ever again with his partner, Luis, who I previously mentioned, said:

To tell the truth I do not know what will happen. I think that the relationship would continue. As I told you, it is only part of the relationship, although maybe for my partner [anal penetration] would still be important. I do not know. For me there have been many changes. I remembered that before we had sex everyday. Now I have learned that if we do not have sex, nothing is going to happen. Then I suppose that if there is no anal penetration again, nothing will happen. We will learn to enjoy other sensations. Nevertheless, I think it would be very difficult to imagine not having anal penetration at all. I think that would have to happen in a slow process.

In other cases, respondents indicate that they have experienced periods of time in which they have not had anal sex, and they have relied up on touching, kissing or mutual masturbation for sexual pleasure. After many years together these men believe that they cannot base their relationship only on the type of sexual practices. In this sense, these men report that without anal sex their relationship most likely would continue throughout time: *"We never had penetration as something important [. . .] because now we almost have 1 year without anal penetration and the relationship continues. After 15 years of living together we cannot base our affective relationship exclusively on sex."* These are the words of Manuel, a thirty-eight year old man, who four years prior to the interview was diagnosed with HIV.

Marcos, another man whom I asked what would happen without anal penetration, also agreed that the relationship would continue. In fact he had already passed through that process. Marcos has been HIV-positive for ten years. He was diagnosed one year after he met his first discordant partner and with whom he lasted for nine years. Giving answer to my question, Marcos says, *"In fact our relationship continued [without anal penetration]. Out of nine years, we did not have sexual relations in two of them, and we continued together. We didn't have anal penetration in all sexual relations. Sometimes it was simply mutual masturbation or ejaculating together to satisfy our needs."* Marcos is now thirty-three years old and he has another partner who, like the previous one, is also HIV-negative. They have been together less than two years.

9.5 Meanings attached to semen

All men, regardless of their HIV status, knew about the risk of transmission that direct contact with semen conveys. Most of them report stopping such contact to avoid infection or re-infection. Some of them (fifteen out of forty-four), nevertheless, still report having this practice with their current partner and some others (thirteen out of forty-four) mentioned their experience with previous partners when they did not know their HIV status. In both cases, their stories help us understand circumstances in which gay men engage in risky sex. These men report liking to have direct contact with semen for what this fluid represents for them: the climax of sex. It is the culmination of physical pleasure. But associated with physical pleasure, men also express other meanings attached to semen.

This issue came up spontaneously during my interviews. I did not take it into consideration in the design of the original interview guide, but as I progressed in the fieldwork I realized that for some men there was a particular perception of the bodily fluids of their partner. The following sections present different scenarios in which men have been in contact with partner's bodily fluids and the different reactions to those

situations. Although there are a lot of similarities between HIV-positive and HIV-negative men, the stories of each group are presented separately for purposes of analysis.

a) The Stories of HIV-Positive Men

Oscar, an HIV-positive man, refers to his current and past relationships, including those that are counted as one night stands. He mentions that he grew up in an environment that prevented him from expressing his sexuality. When he was a teenager, Oscar basically had no way to give free rein to his sexuality. He said that while some of his friends explored their sexuality with their girlfriends, he practiced masturbation with some of them. This practice consisted of self-stimulation in front of other friends that were doing the same thing, although it did not include any kind of contact between them. Oscar believes that through this practice he developed a "special glorification" of semen. When masturbation was over and his friends were gone he used to pick up their underwear to smell any part of their bodies or to check up for sperm stains. The same would happen with the tissue paper used by his friends after masturbation. In this way he started experiencing a lot of excitement and satisfaction by having closer contact with his friends´ fluids:

> *I think that I was limited in my sexual development since I was a child. I belong to a generation, in which there were still porno magazines on the newspaper stands, [and] there were no discotheques, there were no places to meet other men, or I did not know them. There was not a place where you could have a physical release proper for your age. So everything was hidden, limited. At that time I went to another city, which was a more limited society, where everything was based on assumptions and based on spying. Everything [for me] was through looking. There was not a normal physical development, sexual development. So I developed a lot my sexual instinct through being close to my friends and smelling their armpits. There was great excitement for me. He [the friend] arrived in the bathroom, he would change clothes. Then my great sexual moment was to be able to go into the bathroom and to smell the armpits of his t-shirt, between the legs of his underwear, and to see on these clothes stains of semen [. . .] The maximum moment for me was the moment in which there was masturbation with a friend without physical contact, each one in his own bed. When the normal thing was that my friends had their girlfriends, they had penetration [or] they had sexual games of different levels [between them]. In my case there was a strong limitation. So I feel that I*

started developing the experience of semen as the great thing. There was an ejaculation of any of my friends and well [. . .] they cleaned the sperm, the semen and then they threw the paper to the garbage [. . .] Then when he was gone to do something else, I ran to the garbage can and I would embed in the smelling, in the sensations [that it produced in me], and I would rub it against all my parts. So there was [in me] like a development, may be a little sick of this situation. Something not very normal.

Oscar had his first sexual experience at the age of eighteen in a relationship that lasted for thirteen years. He describes that after so many years of not being able to fulfill his sexual desires, receiving his partners semen through oral or anal sex became as the symbol of something orgasmic, the complete fulfillment of so many years of sexual frustration. Oscar became, then, obsessed with touching or having his partner's semen as the maximum point that he could reach through sex.

I don't know if it is normal, but I have had sexual needs since I was eleven years old and I had total frustration for not being able to develop it [my sexuality] until the age of eighteen [when I had my first sexual partner], this one that I was telling you that lasted thirteen years [. . .]It was in that relationship that for the first time I found and I finally had sex (un acoston), kisses, hugs [. . .] a complete sexual relationship. Then being able to have oral sex and receiving in my mouth his ejaculation was like the culmination of many years of not being able to fulfill that need. Then there is a great need and an animal drive in relation to the semen, to ejaculation. Then for me, sexually speaking, the maximum point of excitement [excitation] is the ejaculation of the other person: it is on me or inside me or in my mouth [. . .] I feel that I have not surpassed that frustration; I think that it was back then that [my obsession with semen] started.

The experience of his partner's semen as something orgasmic is so important in Oscar's mind that the mere idea of semen can now turn him on even with people he does not find attractive or after losing an erection due to putting a condom on. To this extent he says that he could be having no real pleasure when having sex, but as ejaculation gets closer, he starts getting a full erection. There are moments even during which he does not have an erection, because maybe he does not really want to have sex or the person does not turn him on, and he starts feeling uncomfortable because he cannot get an erection through manual stimulation. Then, if he starts thinking about receiving semen in his

mouth, he automatically gets turned on and gets an erection. Oscar mentions that he starts feeling sexual pleasure as the culmination of the relationship is getting closer.

> *There is a very funny situation. It could be that I am with a person and that person is not very attractive. That I am not very excited about doing it, about kissing him, penetrating him or being penetrated or giving him oral sex [. . .] even that he is far from my ideal person in physical terms. Then, maybe in a moment of being horny I accepted having physical contact with him, with a sexual excitement that I could qualify as 1/3 or 2/3 [of what it could be [. . .] As I say, if oral sex is the thing that I am doing, at the moment in which his ejaculation is getting closer, then I start having total erection [. . .] In fact there are moments in which I do not have an erection, [because] it was not the moment in which I had to have a sexual relation, but nevertheless I am there [. . .] So I do not have that fascination [excitation], the person does not turn me on. There is not that fluid of scents [aromas] that make me horny [. . .][and] I am trying through masturbation to reach an erection [. . .]and I do not have it and do not reach it and I feel uncomfortable. Then I am giving oral sex and if I start thinking that he is ejaculating in that moment in my mouth [. . .]then, I feel immediately the excitement [la excitacion]. Then it is there that there is mutual sexual pleasure [. . .] and how do I define it? In my case, it was as the culmination of the whole sexual relation. It has been like that since I was younger. That is to say, it is a twisted branch of a tree that never grew straight [fue una rama torcida que jamas se enderezó].*

With his current partner Oscar does not swallow semen anymore but he still receives it during oral sex to spit it out afterwards. The same is true in casual sex. His desire for direct contact with semen is so strong that when his partner is using condoms to penetrate him, he requests his partners to take the condom off before finishing and to ejaculate in his mouth. As he spits the semen he experiences a feeling of disappointment for not being able to keep it in him. It is as if his body were not going to get an important essence of life. When I asked him how he experienced the contact of bodily fluids with his current partner, he said,

> *It is exactly the same. There is no difference. There are moments in which I am with a person and I feel [. . .] and I start to work to have penetration [. . .] and he asks me do you have a condom? And my excitement decreases, it is a moment of disenchantment. If I like the person and I still want to have penetration, then [I accept and] I use condom and lubricant [. . .] and we have penetration. [But] I try to tell him: listen, do not ejaculate in the condom [. . .] when you are about to ejaculate wait and [.*

. .] my goal is that previous to his ejaculation he takes the condom off and I give him oral sex and get his ejaculation in my mouth [. . .] Before [. . .]three years ago, the ejaculation was in-taken [in oral sex], and on anal sex [. . .] well there is no way to extract [. . .] From the last two or three years to the present [. . .] there is the idea of spitting out the ejaculation received in the mouth, but even then there is a disenchantment: Ah! That liquid will not go into my body.

Another HIV-positive man, Raymundo, describes his relationship with a previous partner with whom he had his first and long-term relationship. In this relationship he discovered that he was HIV-positive, and his partner later received positive results too. They practiced sex without condoms all the time and the respondent reports that for him receiving his partner's semen was like receiving life. For Raymundo, the simple idea of knowing that he was ejaculating was nice. Sometimes the direct contact was through anal sex or some other times through oral sex, but in all cases not wearing condoms was more "orgasmic" and "energizing." When I asked him what it meant for him to receive his partner's semen, Raymundo responded that "(*Hijole), it was like receiving life! That is what I was feeling to the degree that I swallowed his semen. I liked it back then and I still like it. That is to say, that he came on me [. . .] he ejaculated in great proportions and I enjoyed it very much, very much, very much. I liked his semen and with him I used to intake it. It gives me life, I like it.*

Now, with his current uninfected partner, with whom he has been together for about six years, he still likes to receive and touch his partner's semen. Nevertheless, in the current relationship, they are careful about his partner not touching the respondent's semen due to his HIV sero-status. Nevertheless, the respondent still practices semen intake or direct contact with his partner's bodily fluids as they assume it does not convey risks for the respondent.

Such ideas of bodily fluids as providing life and energizing the body have meant that wearing condoms is perceived by some men as an unpleasant thing to do, only to preserve their own health and their partner's health. In these cases, condoms are understood as elements that stop them from experiencing sex in its full expression. When I asked Raymundo what it meant for him to use condoms after his diagnosis as HIV-

positive and after a long term relationship where he was not used to wearing them, he said, "*Well, like death! Death [. . .] that is to say, not to use condoms with your partner is exquisite. Exquisite to know that he is receiving your semen and the same with me, that he gave me his semen. Feeling that he was coming inside me was something exquisite."*

Claudio is a thirty-three year old man who also refers to the direct contact with semen as something orgasmic, not only for the physical pleasure that it can provide, but for the imaginary sensations that it stimulates. For him, receiving semen through oral or anal sex was like getting that unique part of the person he was with, the essence of his partner. Before he was diagnosed with HIV, Claudio would enjoy going to bars and meeting people with whom he had sex. Sometimes he used condoms, but if these were not available, he did not care much. In fact, Claudio preferred to practice anal penetration without condoms because it was more pleasurable. He refers to having a special anal sensitivity, so for him being penetrated was one of his preferred practices. If it was without condoms it was better. The simple idea of knowing that somebody was ejaculating inside him was thrilling. The direct contact with semen was so stimulating that, to the extent possible, Claudio would try to taste his partner's semen. When asked what it meant for him to taste other person's semen or not wear a condom when being penetrated, he said,

> *It was orgasmic. It was a more complete sensation. It was to feel that somebody else was placing his semen inside me. Whether it was through anal or oral form.. [. . .] it was like to feel that part of that person was inside me. Even if it was not for love, just simply from somebody that I liked a lot [. . .] It was a greater sensation to know or to feel that something from that person was inside me.*

This man reports using condoms all the time in his current relationship, and although for him it is frustrating having to protect his partner from touching bodily fluids, he says that he has re-conceptualized his own idea about pleasure. Now that he knows that he is HIV-positive, he reports understanding that sex should not be perceived as less pleasurable with condom use. But this perception comes from taking responsibility for not infecting other people and understanding that protection is "a must" in every sexual

relationship. Nevertheless, he would like to be able to be in a relationship where both were HIV-negative, and they did not have any kind of limitation when having sex.

I asked Claudio whether the need to use condoms in his current relationship represents any kind of frustration, as he may feel not getting something important from the person:

> *Now I see the things in a different way. Now, I feel complete having sexual relations with my partner and wearing condoms. It is a question of responsibility. From the moment in which I realized that I am HIV-positive, I assimilated condoms as part of the sexual relations, whatever this is, not only with my partner. And I say this not because I have had a sexual relation with somebody else. Speaking about sexual relations, I have assimilated that you have to wear condoms so I have eliminated the concept that I had before about having less pleasure of less satisfaction.*

Other respondents indicate that their ideas about semen may be an illusion to a great extent. They could really dislike the consistency or flavor of semen most of the times, but when they are with somebody they really like or with someone they have developed feelings for, respondents like to receive their partners' semen because then they feel closer. Even if in the present relationship they may not have such practices to avoid infection or re-infection, they have practiced it in the past or with previous partners. They referred to it as something irrational or even cheesy that they accepted as a result of an infatuation process. Such illusions, nevertheless, have derived in many circumstances from unprotected sex. Jorge, a man in his early forties, refers to his own experience about this matter. He reports that in his current relationship, he does not practice semen intake, but he used to do it in the past. Reference to his past experiences is important because it helps to understand certain situations of risk. To my question of what makes you intake somebody else's semen, he said,

> *I do not know. That cheesy form of doing it [. . .] because when you start thinking about it you say yucky (guacala), but that cheesy form of pleasing or those ghosts and deviances that we have on our head about feeling more used or more [. . .] I do not know, I am not a psychologist, I do not know how to say it [. . .] but it is something that I would not do now, and not because of the virus, but because I do not like it. If you want [. . .] you come in my buttocks, my back or my chest, if you want. But not in the face,*

not that I feel insulted or something, but [now] I do not like how it smells, or its consistency.

Other men report not liking the practice of semen intake. Nevertheless, they have also had this practice in previous relationships, due to what they call the unconsciousness of the first months of a relationship that leads people to make a lot of mistakes, which is another way to refer to the process of infatuation previously mentioned. From a public health perspective, even if practiced for short periods of time, those practices can lead to the transmission of HIV (Eduardo, forty-six years old).

b) The Stories of HIV-Negative Men

Uninfected men report similar perceptions about semen compared to their HIV-positive partners. Pedro, for example, reports reaching maximum orgasm only when there is direct contact with semen. This man in his early twenties thinks that with condoms his sexual life is still satisfactory and that he needs to be protected from undesired health consequences, but he reports that one of his fantasies is to have sex without any kind of barrier. Fears about the potential effects on the physical health of both partners and the need to wear condoms limit to a great extent their complete joy during sexual interaction. When I asked Pedro whether there was an unsatisfactory aspect of his sexual life, he said,

Yes, the pleasure of giving him oral sex to him and [. . .] why not [. . .] feeling when he ejaculates in my mouth [. . .] or feeling the need that he penetrates me or me penetrating him without a condom, having the feeling of finishing without condoms [. . .] when he ejaculates feeling his semen in all my body [. . .] I don't know something like that [. . .] [To me this represents} my fantasies [. . .] it means my complete excitement and satisfaction, that it is what I really like. When we have sexual relations [. . .] when we reach the orgasm I wish to I could feel him completely, not only ejaculate for the sake of ejaculation [. . .] but more that everything I would like to get total satisfaction, I would like to get a complete orgasm and finish [. . .] to feel that the sexual relation was in the way I wanted to.

Not all men currently endorse a positive association with bodily fluids, particularly with semen. Many of these men used to enjoy direct contact with bodily fluids in the past, but the presence of HIV has changed their attitudes. When their

partners were diagnosed with HIV or when they engaged in a discordant relationship, their perceptions of semen changed due to their fears of HIV infection. From the idea of pleasure or mutual bonding they went to the idea of dislike. To this extent, Ricardo, a thirty-nine year old man, compares his attitudes about bodily fluids throughout time depending on the HIV status of his partners. It is clear that his perceptions have changed:

> *One of the things that excited me and that I enjoyed more was the sensation of feeling him [his uninfected partner comes in my mouth and the flavor of his semen. In fact [later on] with my sero-discordant partners [. . .] the sperm is disgusting, and this [undesired] feeling has transcended until the present. At the beginning [with my uninfected partner] my normal reaction, my sexual or psychological reactions with regard to the sperm were that it was nice, cool, and [. . .] nowadays it is more like a feeling of disgust [. . .] and I think that it is the result of associating it with something bad, the virus and the infection.*

Jesus is another HIV-negative man who also reports that with his current partner he does not ingest semen, but in a previous relationship he did so. Jesus reports that with that man he was truly in love. He refers to this man as the one he has loved the most. In this case, ingesting semen from his partner was like a ritual because it was like "eating" or getting something special from a man that triggered in him a lot of passion and desire. In his discourse, feeling his partner's semen went far beyond reaching pleasure exclusively through ejaculation. It also meant some type of bonding with his partner. Now, after a lot of time has passed, he rationalized the situation and he thinks everything was something produced in his head, but at the time there was something compelling about having direct contact with partner's bodily fluids. When Jesus talks about that previous relationship with an HIV-negative partner (like him) in which they did not wear condoms for oral sex, he says,

> *it was wonderful. What happens is that I was fully in love with that person. Maybe he has been the only person that I have really loved with all my heart. I was fully in love. For me in-taking his semen was a plus [. . .] it was like a ritual, because I was very emotionally embedded into him [emotional complicity]. I was so in love that it was like a ritual. It was not only sex for the sake of having sex, but it involved a ritual the thing of in-taking his semen [. . .] and, [. . .] it has been the only time in which that has occurred. After that I realized that I should not have done that [. . .] no matter how deeply in love I was.*

Other men report having practiced oral sex without condoms and having been in direct contact with their partners' bodily fluids. These men do not necessarily like the idea of in-taking partners' semen, although they report enjoying oral sex without condoms. In the past they allowed their partners to finish in their mouth as a form of pleasing them, but they avoided in-taking it. In spite of this, after discovering their discordance regarding HIV they stopped having direct contact with partner's semen, although they still perform oral sex without condoms. When their partners practice oral sex on them, there is less concern about potential health problems for the partner:

> *It is not mutual, because each one has what he likes better. Evidently, my partner likes me to give him oral sex and I like to give him oral sex too, but I also like that he gives me oral sex. [Nevertheless] he tells me that his expertise is in other things. But this is not an impediment for him to give me oral sex. Well, I never intake the semen, not before, not now, never. Neither with him nor somebody else. I don't like it [laughs]. Nevertheless, before he told me his sero-status I used to give him oral sex and I let him finish in my mouth and later I would go and spit it out or whatever [. . .] now not anymore. I continue giving him oral sex up to the point where he says: no more [. . .] and I let him finish by himself. When he gives me oral sex [. . .] then, before, and now [. . .] sometimes he likes to give me oral sex and he makes me finish and he not only keeps it in his mouth, but sometimes he likes to intake it. It is not a very common practice but it happens (Tomas, twenty-four years old).*

9.6 Conclusions

This chapter presents the significance of sex for the men interviewed, paying particular attention to anal intercourse. Like previous chapters, it recuperates the theoretical premises that individuals behave toward things based on the meanings they attach to such things, and that such meanings change throughout time due to processes of personal interpretation and social interaction. As will be shown, those meanings have consequences for people's actions and their health and should be part of public health campaigns intended to reduce or eliminate practices of unprotected sex. Results demonstrate, for example, that perceptions of sexual interaction are a key dimension of

respondents' relationships, regardless of the known risks of HIV transmission or secondary health problems. Such perceptions about sex change throughout time, so the age of respondents or time of being in the relationship play a role in the weight they give to sex. In general, for younger men or those in couples of recent formation, sexual interaction is more important for the maintenance of the relationship. For older men or those in long-term relationships, sex is perceived as necessary, but they start focusing on the companionship aspect of the relationship. In practically all cases men do not perceive themselves without any kind of sexual interaction; neither do they base this exclusively on touching or kissing. At some point or another in the relationship men perceive the existence of anal intercourse as necessary, a practice that carries a risk of infection even if condoms are used. In all cases, the presence of HIV represents a challenge for discordant couples because in spite of their fears of transmission or secondary health problems, lack of anal intercourse is something problematic for their relationship. Having no sex at all, including anal intercourse, is perceived as potentially damaging for the relationship.

This situation poses some limits to health programs that promote practices of safe sex other than anal penetration. Even if men incorporate or increase the frequency of mutual masturbation, touching and kissing as ways of reaching orgasm, they will also expect to have anal penetration. To reduce practices of risk that include contact with bodily fluids, campaigns should include in their messages the idea that protected sex is a form of showing commitment to the relationship. Campaigns should transform men's perception that unprotected sex and contact with bodily fluids is a form of expressing mutual support and commitment to the relationship: going from understanding the relationship as abandoning oneself to a partner to one of mutual responsibility.

Changes in men's perceptions are exemplified by respondents' views of contact with bodily fluids, particularly semen, a practice of high risk of HIV transmission. On the one hand, there are men who currently have sexual practices that include direct exposure to semen. On the other hand, there are men who had such practices in the past. For men currently in contact with bodily fluids, the presence of semen is the maximum expression of orgasm, and they understood this as physical pleasure as a form to consolidate affective bonds. They report that there cannot be complete satisfaction if body interaction

does not culminate in ejaculation. These men refer to semen as something energizing. The direct contact with their partners' semen makes them feel as if they were receiving something special and unique from the person they are engaged with. It is a form of being mutually close in their affective relationship. For this reason when they have to wear a condom, they express a feeling of disappointment because they think condoms are a barrier that prevents them from having more intimate contact and maximizing their pleasure. In extreme cases, not being able to receive semen from their partners due to the use of condoms makes some men lose erections or interest in sex.

For men who in the past had direct contact with partner's semen, interviews show that they also endorsed positive ideas about semen at the time: something orgasmic that represented getting something special from the partner. Nevertheless, a series of events changed their perceptions: understanding that to provide good support to their partners, they both have to care for each other's health. Although they would like to be in a situation where condoms were not needed, they understand that they must take precautions. HIV-negative men also report that fears of infection have been responsible for such change and they have transcended the previous association of direct contact with semen with pleasure and intimacy. But once again, this has occurred in conjunction with the understanding of commitment as mutual responsibility to maintain good health.

Chapter 10: Challenges of Being in a HIV-Discordant Couple

10.1 Introduction

The purpose of this chapter is to talk about the most important challenges that men face in HIV-discordant couples. Respondents basically talk about things that are different in their current relationship when compared to living in a concordant couple in which both partners are of the same HIV status. The chapter presents the results in two major sections: one expressing the point of view of HIV-negative men and the other the point of view of HIV-positive men. Results help to foster understanding of the particular dynamics that are present in HIV discordant-couples, as well as how these can interfere with their sexual lives.

Although the analysis is based on individual perceptions of their HIV-discordant situation, the results point to the lack of institutional programs to attend the needs of both members of the couple. It is evident throughout the analysis that respondents complain about insufficient attention to the fears or needs of informants and the discriminatory attitudes that still prevail in certain medical settings. MSM still face inadequate treatment by some health personnel due to their sexual orientation, and little recognition is given to the rights of HIV-negative partners to be informed and to be included within a program that addresses their doubts and the uncertainties about their current discordant situation.

10.2 Perspective of HIV-negative Informants

This section illustrates the challenges of being in an HIV-discordant couple from the perspective of HIV-negative partners. The analysis of the interviews uncovered three major themes in this regard: partners' constant mood changes as an effect of medications and as source of conflict in the relationship; respondents' fears of infection and their perceived need to show support to their partner (which may lead to undesired or unprotected sexual relations); respondents' perception that their own needs as HIV-negative men are put aside both within the relationship and by health institutions.

a) Mood Changes

For HIV-negative men, their partners' constant mood changes represent one difficulty of living in a discordant relationship. Due to the idea of death as something proximate and the effects of medicine, HIV-positive men easily go from happiness to anger and/or to depression. HIV-negative men report that sometimes it is impossible to fully understand their partners, even if the relationship is one of mutual and unconditional support. Some HIV-negative men describe that it is difficult to live in a discordant relationship because no matter how much effort they do, they will not be able to experience the same feelings of anxiety and vulnerability that their partners have unless they also become HIV-positive. HIV-negative men report that when their partners unexpectedly get mad or irritable, they simply need to be patient, and there is no way to do much about it. Roberto is a twenty-six year old man in a six-month relationship with an HIV-positive partner. When he compares his current relationship with previous relationships with uninfected men, he said,

> *(Hijole) [. . .] there are a lot of challenges because [. . .] even if you want to understand your partner, you will not be able to really understand him until you are in the same situation [. . .] you can listen to him [. . .] but I don't think that you can understand him a 100 percent until you are in the same situation [. . .] The challenges are many [. . .] the mental problems caused by the medicines [. . .] He suddenly feels vulnerable [. . .] the anxiety [. . .] the quick mood changes [. . .] This is for me a challenge. Because I am a person with patience, but there is a moment in which you lose your patience [. . .]and I think it is the result of all this [. . .] [and] of the sexual relations too [. . .] It has been for me a challenge, to tell the truth, very difficult and even exhausting at some point. [But] everything is a question of flexibility on both sides.*

Diego is another man who also refers to his partner's mood changes as an important challenge, although he placed them alongside other factors: his own fears of infection and his interest in providing good support to his partner. This man is in his early thirties and has been aware of his partner's HIV status for about one and a half years:

> *The first risk it has been to get infected and everything [. . .] the way in which my life would change for that, definitively. My second challenge is to support him, to be there [with him] to support him. [And] there is something that it has been difficult, because due to the medicines [. . .] for*

what he and the physician have told me [. . .] is that due to the medicines, his mood drastically changes. Then if he does not take his medicines he could be in a very bad mood and that has been very difficult for me to understand and to cope with: the bad and changing mood. That has been the most difficult thing [. . .] [and] at the end you have to say: if I know what is the reason or part of the reason, I have to bear with it and be there.

For HIV-negative respondents, their partners' mood changes and their incapacities to express their feelings make the small problems between them grow to a large scale. They indicate that it is difficult to predict their partners in terms of affection because sometimes their partners are close and sometimes distant in the relationship. For HIV-negative respondents, this brings problems to the relationship because they do not always receive the care and affection that they are expecting in return. Jose, a thirty-three years old man in a relationship of 6 years, describes very well such a situation:

I feel that living with a person with HIV, that is positive, is very complicated because his moods vary a lot. There are times in which he is very happy, there are times in which he is very depressed, or he is mad. Then it is very complicated to live with them [people with HIV], because sometimes he is distant, or sometimes he is very close. Then you have to live with those moods [. . .] There is a moment in which I got desperate, because our personalities are very different [. . .]All human beings think that everybody has a magic power to know the mood in which you woke up today or the way you feel today. I believe it is part of communication, of mutual feedback to say: today I feel bad for this, this is hurting me, or I have thought about this. Then it is here where everything gets complicated. I think that if we had that communication and one hundred percent emotional openness, we could change many things.

Ricardo is an HIV-negative man who also refers to his partner's mood as a cause for conflict in the relationship. With regard to the four years that his first discordant relationship lasted, Ricardo emphasized the depression that his partner had and how this was difficult to cope with at times. The confrontation with death and its perception as inevitable and fatal made his partner susceptible to depression. In addition, Ricardo's partner had experienced the death of his previous partner as a consequence of AIDS, and he visualized it as a mirror of what he himself would probably have to go through. In this circumstance, Ricardo felt compelled to show support and to try to cheer his partner up,

but after a certain amount time he was also experiencing feelings of depression and anxiety, to a point that they had to stop seeing each other for several months until his partner felt better and the depression was minimized. In this sense, it seems that one important challenge for HIV-negative men in discordant couples is to be able to support their partners and help the relationship continue, without losing themselves in feelings of exhaustion and anxiety. Achieving this is especially difficult when respondents lack supportive social and professional networks that are both aware of their discordance surrounding HIV and willing to provide advice and assistance when needed:

> *Everything [laughs]. There are many factors. I already talked about it very briefly: this was my first HIV-discordant relationship, that is to say, the second relationship in my life. One of the problems it was the depression that he had, his illness and the possibility of death that at the time was seen as a verdict of death [. . .] and as instant death [. . .] and being confronted with that. You, as partner, obviously, do not want to see that your partner feels bad and you try to support him as much as possible. When he was having this depression I stayed with him for three months. After that I couldn't do anything else because I was getting depressed with him. I used to prepare his break fast in the morning and I would care for him so he had good nutrition and he took the medications [. . .] and he reacted as an irresponsible child: I do not want to take this because it makes me vomit and yucky and there was a moment in which I told him: you are responsible for your life and I am responsible for mine and good [. . .] The relationship was broken [. . .][I told him] "I cannot help you with your depression, so I need to separate… until you are able to understand." [. . .] Then we separated for three months. After those three months he had overcome his depression and the quality of our relationship got much better. This is one of the factors [that you find in an HIV discordant relationship] and it depends in which stage is your knowledge of being sero-positive.*

In other situations, HIV-negative men reported that the progression of illness in combination with a process of aging made their partners especially vulnerable to feelings of jealousy. Especially when respondents were much younger than their HIV-positive partners, the relationship turned problematic: HIV-positive men tended to become more possessive due to fears of being left for other men. Miguel is a man who reports on this. He indicates that at the time when he was HIV-negative and his partner HIV-positive, his partner was very jealous and possessive with him. With time this situation became more

evident, and it was the reason for breaking up a relationship that had lasted almost five years.

> *Obviously the years went by and he became older and with his illness he felt insecure, he was insecure about me leaving him. He became more jealous and possessive than ever before. That was the cause for us to break up [. . .] We broke up many times and we came back [. . .] until I got really tired and I realized that I could live without him. It was like a destructive relationship, a relationship of dependency [. . .] because as I told you, he helped me economically, he treated me well, and maybe the loneliness or whatever you want to call it [. . .] and it was something very strong, but later I realized that I practically did not need anything from him, that I could live without him.*

Miguel became HIV-positive many years after his partner died. He reports that he probably got infected through casual sex.

b) Fears of Infection

HIV-negative men agreed that they had constants fears of becoming infected. Especially if the news of HIV sero-discordance was recent, they report feeling afraid of getting the virus after each sexual relation. Initially, some respondents had fears of infection even from any minor cut on their partners or by using the same bathroom. These respondents have observed from their partners the downfalls of being sero-positive and would not like to experience the same situations: discrimination, lack of medicine, health problems, and so on.

Felipe, for example, reports the extra care he takes in everyday life and while having sex with his current partner. He compares the three and a half years in which he has been aware of his partner's HIV status with other relationships where his partners were negative or he assumed them to be negative:

> *At the beginning it was very difficult for me. I was even afraid of using the same bathroom where he showered and it is difficult because there are many things that you cannot share. In a normal relationship between two persons you say: well it does not matter to use the same nail clipper or other things [. . .] [but in this relationship] you have to be careful that the nail clippers are not the same. You have to check that the condom is not broken [. . .] which is something curious, because you have other relations [with people] and you do not know whether he has HIV or not, but as you think he does not have it [. . .] then you do not pay attention whether the*

condom is broken [. . .] and here [in my current relationship] it is like you have to be cautious [. . .]which makes it a little bit more complicated.

In spite of these fears, respondents report feeling compelled not to show distance from partners. They did not feel comfortable to openly use or discuss some protection measures that could potentially hurt their partners or make them feel rejected. Respondents felt they had to show all their support and affection to their partners and not show any sign of weaknesses. In some cases, that lack of communication led HIV-negative men to have sex without really wanting it or to not enjoying sex due to the constant reminder of the HIV status of the partner. When talking about his sexual practices, Alejandro, a young man in a six month relationship, says:

I have only penetrated him twice, obviously wearing a condom, but for me that's very difficult. I do it with a lot of fears. I do not enjoy my sexual life because I am afraid. I am thinking all the time that I can get infected, that I do not want to get infected. Even if am very careful and I wear condoms, the fears to getting infected are always present [. . .] I feel that he needs that I give him affection. Then if [I] feel the need, sometimes even without willing it or even if having fears, of showing him that I love him and that I am with him and that I am not afraid of the situation.

Pedro is another man who compares his current relationship with uninfected partners. He basically talks about the multiple things that he cannot do due to fears of infection and how those limitations can make their sexual life difficult. He complains about not being able to have oral sex or penetration without condoms, as well as not being able to share personal items:

Unfortunately I cannot give oral sex [in my current relationship]. I cannot penetrate him without condoms. If there is a fissure, [or] some problem that we have, then I cannot do it with total freedom because I have fears [of infection] [. . .] [Before with an uninfected partner] there was all the freedom that "you do to me or I do to you without prevention, without using any method of prevention." It was nice to feel the skin without plastic. You did not have any kind of limitation; you could do it freely without knowing [or thinking] that you are at risk of anything. But now [in the current relationship] you limit your self, "you cannot do this without this [condoms]," or that "it is better not to do it like that because you can infect me" [. . .] or "I cannot do it because I have an open wound" (me corte) [. . .] There are many situations. For example, it is the same with

regard to the medications and the things that he uses: "you did not use or clean with [substance], right? [. . .] When you are [having sex] with a "normal" person you have the freedom of doing whatever you want, but when it is a person with HIV it is a little bit difficult because when you are having sex you have to be careful about everything (hasta de la mosca que pasa). When you are about to ejaculate [. . .]it is the fears that you maybe have an open fissure and it should not even enter a drop of semen, because then you feel that you got infected or you need to avoid any contact with semen with a fissure in your body.

Fears in HIV-negative men were also present in the uncertainty with which they perceived their relationships, especially those of recent formation. These men were wondering what would happen if their partners died. Such uncertainty led some HIV-negative men to the idea of not wanting to develop strong ties to their partners or not wanting to make long term plans with them. Although they were willing to continue the relationship, they wanted to plan their own lives as an individual project, in which they could include their partners without becoming dependent on them. To this extent Jesus, aware of the discordance since the first day he met his partner, eight months prior to the interview, indicates,

I believe that fears are always present and I think that you do not launch yourself so easily to make plans for the future. For example, even if you don't say it to your partner, if you think that he can die tomorrow [. . .] because even if his health is stable, and his entire medical examinations go well [. . .] the possibility that suddenly something generates a health problem is there. Then you feel afraid, like planning things for the future makes you afraid [. . .] [For example] with the first person I lived [with] as a partner, we lived together for five years and during the five years we had the possibility of making plans for the future: thinking about moving to a new house, to buy things, in doing things together, in making plans for our life [. . .] even if at the end I send him to hell, but you still plan your life together. And when you know that your partner is HIV-positive you are afraid of making those plans together, because you do not want to do a series of efforts for something that you know may end one day. Because maybe you have a plan: let's go to live to Cuernavaca, for example, and you are afraid of being involved in the effort of saving, buying things, talking about the possibility of moving to a new house, because may be he will be only one or two years [. . .] That touches you and makes you think "what for?" Because you have in mind that maybe he dies tomorrow and what about my plans [. . .] In my case, independently that we are partners and we live like partners, I have my own personal

plan for my life, as an individual [. . .] in which it does not matter if I am his partner or not. That is to say, I have my plan for me [. . .] with or without him.

In some situations such fears of infection and uncertainty about the future lead some HIV respondents to thoughts of breaking up the relationship, especially when emotional bonds are not well established. Some of these respondents express that they have found themselves using small problems as excuses to get mad with their partners. This is a way that they try to detach from the relationship and avoid more commitment or sex with their partners. They say that unconsciously they are looking to break up, although in practice they are not able to carry it out for the emotional conflict that it causes them and because in the end they like their partners.

This situation is different in couples of long-term formation, because respondents had already engaged in a common project. HIV-negative men in these cases were willing to embark in whatever the future could bring them along with their partners. In these couples, HIV-negative men also expressed fears of infection, but they were more willing to continue their relationship. They would not see the possible death of their partner as bringing a total end to their future as a couple. They had together gone such a long way that plans of being together were already established through their everyday experiences and sharing.

c) Who cares about me?

HIV-negative men reported strong feelings of isolation. They expressed frustration for being the only or major source of support for their partners without having any way to solve their own doubts or anxieties. Respondents had, in many cases, nobody to talk about the problems in their relationship because they had to keep their partners' sero-status confidential. Some respondents said they were the only person that their partners trusted, and respondents felt obligated to stay with them all the time to avoid any possible fallback in their health. They said that as a result of their commitment to their partners, they somehow had put aside their own interests and desires, and in some cases they stopped having as active a social life as before: they stopped going to bars or parties

due to the delicate health of their partners; in many cases they also stopped visiting with friends.

Respondents also said that sometimes they felt as if they had to give more in the relationship than the HIV-positive partner: to invest more in understanding their partners' constant emotional and physical crises derived from the virus and the medications. Due to the different status regarding HIV, respondents express that their partners' health situation had become the center of attention, while the respondents' own needs had been unintentionally left aside. This problem occurred within the couples' interactions, as well as within any institution that attended to the partners' health crisis.

This seems to be the manifestation of a lack of health programs or support groups that actively include HIV-negative men in discordant couples. Respondents complain that their needs as HIV-negative partners are dismissed and not taken into account by physicians and counselors. In the best of the cases they are "warned" by physicians about the risk of infection, but there is not an integral program to help them face their daily problems within the relationship: their desire to continue with their partners and, at the same time, their fears of infection; in some cases, the lack of partners' cooperation to look for information and to improve their quality of life; their own inexperience and fears about how to deal with the situation if their partners present health crises (whether because of the virus or the wrong use of some medicines.

Perhaps the fact that HIV-negative men are not part of public health programs along with the inexistence of specific programs for HIV-discordant couples results from medical institutions and physicians not considering these men as worthy speakers. In some medical settings, as well as in most sectors of society, the disproval of sexual and affective relations between persons of the same sex prevails. For example, some HIV-negative men complained that physicians do not consider them as having the right to information or being able to make decisions with respect to their partners' health. In some other cases, respondents report having been treated with disrespect and discrimination by nurses or medical personnel when going with their partners for medical attention.

The lack of programs attending to the needs of uninfected men in discordant relationships and the anxieties of these men to provide good care to their partners is expressed by Luis, whose partner was diagnosed with HIV two years ago, after five years in the relationship:

> *One of my main challenges is to give him all my support, but, with quality. [. . .] We do not know if he is going to die first [. . .]It could be him or it could be me [. . .] So the time that we are together [. . .] I want to give him good support (con calidad) [. . .][although] there aren't groups for people like in my case are discordant to HIV and do not know how to provide that support and help [. . .] and sometimes we feel overwhelmed with fears and [. .] we want to find the solution but we are afraid of making mistakes [. . .] [There is] a lack of information and assistance to provide, not only in my case but in all other couples, to be able to provide good help. Because I would think that the help [that I gave him] during these two years was adequate and perfect. Nevertheless I need to compare myself [with others or to know] that "this is the correct or most adequate assistance" [. . .] to not be like a military formation in a straight line, but to be more flexible. That's what makes me not be satisfied: not knowing whether I provide good help.*

Another example of HIV-negative men having problems with anxiety about not knowing how to take care of their partners is expressed by Tomas. He has been in a relationship for about two years, and he has been aware of their discordance for more than one year. He would like to know what to do if his partner gets sick and when the medicine is not working, as well as how to deal with his partner's constant mood changes. Tomas expressed his desire to provide good care for his partner but sometimes he feels he does not know how:

> *Maybe the greatest challenge for me, as the uninfected partner, is to provide him confidence. That's a challenge. How can I show him that I am not afraid of him, that I know there are risks [of infection], but that it is not a problem. How can I show him that I also feel co-responsible of his own life [. . .] and sometimes, for example, I see in his eyes [. . .]because sometimes he feels bad, or something hurts him [. . .] or when he gets sick with the flu [. . .] I notice that he is afraid that it could potentially be something that came as a consequence of his illness; it gets complicated [. . .] and then I am there telling him that nothing is going to happen [. . .] "you are going to be ok." And as I say], he always gets better but sometimes I can see fears in his eyes. So my greatest challenge is making him feel that he is going to be ok [. . .] and very importantly is that I tell*

myself: how can I transmit to him that if I am with him now, that if am worried for him now, then when the moment arrives [. . .] if the final stages of the illness arrives [. . .] that I am going to stay with him [. . .] and that I will still love him as before [. . .] and that maybe it is going to hurt me but I am not going to feel disgust [aversion] or anything [. . .]This is the part that is more challenging for me.

Ramiro, in a five month relationship, also refers to the need for health programs that focus on the couple rather than only on the individual with HIV*: "If it were possible I would be in favor of integral programs that not only offers medicines or focuses on [changing] behavior, but a program that focuses on the couple, not only on the individual [. . .] A program [that offers] prevention, education, and orientation about [. . .] the emotional changes that a person has as a consequence of the medicine.*

10.3 Perspectives of HIV-positive Informants

This section focuses on the challenges of living in an HIV-discordant couple as it is viewed by HIV-positive respondents. The analysis highlights four major themes: respondents' fears of losing their current partners due to respondents' HIV status; dissatisfaction with sexual life due to fears of infection and re-infection and to the consequent elimination of sexual practices that are pleasant to respondents; learning to keep their self-esteem up and to avoid letting themselves get down about the illness; and respondents' own fears of transmitting the virus to the partner.

a) Possibility of Losing a Partner

One of the important challenges that many HIV-positive men experience in a discordant relationship is the effort to maintain their partnership. A lot of men interviewed expressed worries that, due to fears of infection, their partners would find a man without HIV and leave them. For that reason, respondents report feelings of anxiety and having to double their efforts in the relationship to make sure that their partners are happy. From their perspective, any other man would have a better chance of getting the

attention of their partners, even if such a man were wrongly considered HIV-negative. The following two men exemplify that situation. The first corresponds to Alberto, a twenty-five year old man who was diagnosed HIV-positive one year ago and who is in a seven month relationship. The second corresponds to Sebastian, a thirty-three year old man who received a positive HIV diagnosis seven months ago and who has been in his current relationship the last five months. In both cases they basically disclosed their HIV status to their partners since the beginning of the relationship, and they report having experienced fears of being abandoned by their partner. Alberto, for example, says,

> *There are a lot of fears, because in spite of him saying he loves [me] a lot [. . .] there are many things that someone that is HIV-positive feels very afraid of [. . .] because he[my partner] could get tired at any moment [. . .] then he can tell me "I do not have anything, then why should I be tied up to a person that is sick" [. . .] that is may greatest fear [. . .] In my case, I have to double my effort to avoid him from leaving. Obviously I don't want to have him tied up [to me] but it is difficult in the sense that "you don't have anything, [and] I do have [HIV]." Then I have to do everything that is possible so he does not get interested in a man who does not have it [HIV]. That part [of the relationship] is painful.*

Sebastian also reports that through talking to HIV-positive friends he has realized that they all share the same worries about being rejected or abandoned by their partners. Such worries begin when they disclose their HIV status to see what the initial reaction of their partners will be, and they continue along with the relationship as they try to keep it on good terms:

> *At the beginning I was very afraid. I thought that being discordant was going to make a [difficult] relationship [. . .] I was very afraid, because I thought: if he is ok and he suddenly finds somebody else [. . .] And that is something that could probably happen. I believe that it can happen [. . .] Besides the fact that many people in a relationship like this [. . .] if they know it [. . .] everybody is afraid of being rejected. Because [when I was HIV-negative] I had the same kind of fears [of being infected]. I have talked over this with many friends [. . .] and we have all gone through the same thing. The biggest challenge is to face reality: to tell the things as they are and to accept it, for good or for bad. That is the biggest challenge.*

Some HIV-positive men also report that unlike the time when they were not HIV-positive, now they experience hesitation and doubts about breaking off their relationship. In their current situation they refrain from doing so because they feel that it would be hard to start a new relationship and to disclose their HIV status again. Although with time they have learned to live with the virus, they are not sure that other men will be willing to take the risk or will have the courage to live with them. They report that it would be hard to start a new relationship and to have to experience the same process of gaining the trust of the other person and disclosing their sero-status again. They have fears that they would be rejected or that they would have problems in their sexual lives as couples because of their HIV discordance. Oscar, for example, describes the difficulties of breaking up with his current partner. In this case, they started dating six years ago when he was not yet diagnosed with HIV. One month after meeting each other, Oscar received a positive diagnosis of HIV. His partner reacted positively, and they have been together since then. Oscar reports being afraid that in a hypothetical new relationship, he would have to talk up front about his HIV status and that his new partner would get scared of this situation.

> *When we have had problems, [being HIV-positive] can stop me.. [. . .] it has stopped me in fact [from breaking up]. In two occasions we had very strong problems and we broke up the relationship. It is in that moment when I said: (chirriones), I do not have my partner anymore. Now I will have to start with a new partner and how am I going to tell him? Because now I am conscious that before starting a new relationship I already have HIV. So I know that it is not going to be easy to find a person that wants to be with me having HIV. That [occurred] to me these two times in which I had problems with my partner [. . .] There had been other moments, but in these two it was very clear that it was something that restrained me, like saying: I can't end this relationship, because later how am I going to have another? Do you understand me? At the beginning of our relationship there was honesty on both sides, because we did not know that we [I] had something [the virus]. And we continued. His attitude has been very cool, it has been admirable. There has not been a problem with that, it is not an issue [. . .] but it would become an issue if I finish with him, then in the next relationship I would have to start saying: "hey, I am attracted to you [. . .] cool, I love you [. . .] we are adorable, let's start a relationship [. . .]and suddenly [. . .]I have this problem [HIV]. It would not be honest."*

b) Dissatisfaction with Sexual Life

b.1) Lack of Interest in Sex

Associated with fears of losing their partner, some HIV-positive men perceive lack or decrement of sexual life as a challenge to their relationship (five out of twenty-three. In some cases their sexual life has been affected by a partner's withdrawal from intimacy. HIV-positive men report that partner shows no interest in having sex anymore and that probably he is having an affair with other men. It is not clear whether such distance between the couple is due to the HIV status of the informant or a decrease of interest in sex due to many years living together (or both). Nevertheless, respondents perceive lack of sexual activity as signs of rejection and partner's doubt about continuing taking risks with them. This is the situation of HIV-positive men who are still interested in continuing having sex with their partner, but who think that such desire is not reciprocated. They indicate feeling frustrated for their unwanted lack of sex in the relationship. Sometimes such feeling is mixed with fears of infecting other men, which also leads them to think that may be they should stop being sexually active.

Raul, who has been in a relationship for 8 years and since the beginning he talked up front about his HIV status with his partner. Complaining for not having sex as frequently, Raul says:

> *it is that physical need that I have of feeling loved, of receiving affection, of feeling that I am attracted to somebody, that somebody needs me and loves me… (Not having this) has made me insecure. It has made me feel that maybe because I am HIV-positive I do not have that right… to enjoy that. And at the same time I am afraid of infecting other people because I feel that it would not be fair…because not for satisfying my self… So when I need a person and I look for him and I do not find him and I feel alone in spite of being surrounded by so many people at work and with my family… and in spite of sleeping with somebody that ignores me and that makes me feel that I do not have that right.*

In addition to feelings of jealousy or complaining for partner's having cheated, HIV-positive men are afraid that partner can contract HIV with somebody else and complain later with respondent for it. Respondents were also worried that partner can

catch other STD through casual sex and bring it to respondent, which could negatively affect their health status.

In other situations, some HIV-positive men report fears of losing their partners because of their own lack of interest in sex. Due to the antiretroviral or to circumstances in which they have been sick, they have not been able to have sex as frequently as before. These men report that for this situation their partners can potentially look for another men somewhere else, putting their relationship at risk of breaking up. The following description corresponds to Enrique, a man in a relationship of eight years, four of which he has had HIV:

> *We currently do not have a sexual life. We cannot have them now until we define what we want of our relationship [. . .] whether we want to continue with the practices that we had before [. . .] I feel that he still has interest in having sex with me, but it is I who does not want [it]. He says that I am an egoist, [that] if we want to continue, we also need to have sex. That is what he argues, that sexual life is important for a relationship.*

b.2) Sex Has Changed for the Worse

In other cases the sexual life of the couple has been affected by reducing or eliminating practices that are perceived as having the highest risk for HIV transmission. Or if these practices are present, they produce constant fears and remorse in the respondents' partners. HIV-positive men indicate that the presence of the virus does not allow them to experiment with their sexual lives as freely as before. They express that such limitations create problems for themselves and the couple in the long run. Neither respondents nor their partners feel they are living plentiful sexual lives, and they have fears that such situations will affect their future relationship.

A man with HIV for ten years, Hector, describes the time that his partner was HIV-negative. Talking about two initial years in which they were HIV discordant (later on his partner was also diagnosed with HIV), he says:

> *I think it was difficult because we did not have [. . .] the passionate kisses when [we] abandoned [ourselves to each other], like when you do not worry if there is something in your mouth that is bleeding, if you are going to infect your partner. There were some kisses, but not always with total confidence or assured [that nothing would happen]. There was always a situation of "I do not want you to penetrate me because it is risky."*

Besides the fact that condoms can fail, there is the certainty that "you are positive and I am not." Then it is difficult, because although my partner said: "I love you and accept you as you are [. . .] and I assume the risks," but there were always a lot of fears [in me].

Hector also indicates that this situation led him to have sexual affairs outside his current relationship.

HIV-positive men complain that they have to refrain from doing certain practices they like or to do others they do not like too much but that imply less risk of infection for their partners. It was as if the sexual needs of the HIV-positive men were in second place. Some respondents, for example, reported that at times in the relationship they played a receptive role in anal sex, even when they like to play an insertive role. The reason for this was their perception and their partners' belief that by doing so they were reducing the risk of HIV transmission. Jorge, who was diagnosed with HIV twelve years ago, refers to a previous discordant relationship in which he felt rejected by his partner. His partner argued to be exclusively "active" in sexual roles and did not allow the respondent to penetrate him. According to Jorge, the real reason for this situation was that his partner was very afraid of infection. In fact, fears played an important role in their relationship, to the extent that his partner never recognized their relationship as more than merely a friendship, in spite of living and sleeping together. Only when they got into a fight would his partner allow the respondent to penetrate him as a form of making up. A situation of not recognizing a more intimate relationship and just naming it as a friendship also occurred among other interviewees. But certain facts suggest that the discordance regarding HIV prevented these men mutually to recognize the closeness of their intimate relationship, even if they were living as a couple: living together and sharing the same bedroom (even when they had a spare room), having sex on a regular basis and having a monogamous relationship.

When I asked Jorge if he had ever felt rejected, he said:

Yes of course, with the guy I was telling you [about] before [. . .] He was active, because he said he was active. But well [who knows] [. . .] when I met him he said he was bisexual. The time passed by and he said that he was active and at the end [. . .] the next time that I see him I will find him as transvestite because he has evolved very fast. So I do feel that there was

rejection from him [. . .] but due to fears. We were friends [. . .] that fuck and live together and we were faithful [. . .] well, at least I was faithful to him. But I felt rejected by him. In fact, the only times in which he gave me oral sex or let me fuck him, was when he drove me nuts [. . .] when he knew that I was going to tell him "fuck off"(mandarlo a la chingada)[. . .] Only then, he would give me his ass or would perform oral sex on me.

For Jorge, being HIV-positive means that a lot of his sexual fantasies or preferences are put in second place for the sake of protecting his partners. When talking about the things he does not like about his current sexual life, he indicates,

The fact that I am HIV-positive. I do not have as much oral sex as I would like to, because I am not passive [in sexual terms]. I am passive for the circumstances. Because in my head I want to understand that by being passive, and by allowing them to introduce me [to] their dick, I will not infect them [. . .] because there is not that contact of my semen with theirs. In spite of the condom, there can be an accident and condoms can break [. . .] so I am eliminating such possibilities. What's the difference [between before and after my diagnosis of HIV]? Well that I like to receive oral sex [. . .] and I love to give oral sex too. There a re-infection would be intolerable.

Other men, especially those of recent diagnosis, also express their lack of sexual satisfaction due to their own fears of transmitting the virus. Their constant thoughts about the virus while having sex and their doubts about what practices are of real risk prevent them from enjoying sex with their partners regardless of whether they use condoms or not. Referring to the circumstances that impede a plentiful sexual life, Claudio, just recently diagnosed as HIV-positive, says, "*Fears. Fears of not being able to have sex totally free of risk. Not being totally satisfied at the moment of having sex because he [my partner] cannot be in contact with my semen. Or the fact that within the sexual relation, even if we are enjoying it, consciously or unconsciously, we need to [have] certain limitations. That is the problem that I have.*"

c) Learning to Cope with the Disease

Another challenge for the HIV-positive men is to learn how to cope with the illness and its implications. This has been accomplished with the support of their partners

who have helped respondents in many areas such as: visits to physicians, hospitalizations, care for respondents' nutrition and medicine, and care for their well-being in general. Through respondent's interviews, it is clear that HIV discordant couples have passed together through a process of pain, grief and uncertainty. But they have also learned that with medication and proper nutrition the respondent's immune system can improve substantially, as well as their quality of life: once respondents' health is re-established they are more energetic and willing to do things, and they set new goals in their lives. A man diagnosed with HIV two years prior to the interview and engaged to his current partner for more than twenty years, indicates,

> *I think that the biggest challenge is to live and to live well. To live well in all aspects: physical and emotionally, because it is emotionally that this situation tends to kill you, to get you depressed. It puts your immune system down, it kills many of your illusions, but I also feel that all this is temporal. When you say: I finally got through all this, I got tested, and the suffering is over [. . .]Now it comes the moment of [. . .] well we suffer this as a couple, because my partner was also affected a lot [. . .] and the challenge was basically: we are going to go through all this, we will continue on [. . .] doing things, working, [. . .] loving each other [. . .] I got all his support [. . .] in everything [. . .] from A to Z [. . .] so we could go on. When I started with the medical treatment my body had a marvelous reaction, [so] then we continued with our work activities, professional and intimate [life] [. . .] My challenge is to continue with this and I want that my partner [. . .] and I know that he also wants it . . .] In fact when [I received the diagnosis of] AIDS we had a separation, but it was due to working reasons [. . .]He had to be somewhere else [. . .] he had to be in one place and I had to be in another place. Now we have again five months [of] living together [. . .] we always live together. When the diagnosis occurred he went to live to another place and I remained in Mexico City due to work reasons [. . .] and now we have gone back to our activities and this is what we have to fight for [. . .] to continue, right?*

Ismael, another man in a long term relationship (fourteen years) and just recently diagnosed as HIV-positive (5 months), reports that when he gets depressed, his body is at higher risk of any disease, and everything crumbles. For this reason, he say that some of the biggest challenges are not to let himself get down and to keep up everyday a positive attitude about life. This is not easy all the time because happiness or depression come and go continually, and the presence of HIV also juxtaposes with other problems associated

with his job, family, friends and partners. But his own willingness not to give up and the support from his partners play an important role:

> *As a person with HIV, [my biggest challenge] is to overcome this situation, knowing that I am infected. Not to let myself get down [. . .] and fight [. . .] to continue. In addition I have a partner that helps me, he tells me that I should not worry, that we will go on, that every thing is ok, that there will be a cure very soon, that we need to make an effort and that he is willing to fight [this situation] with me. In fact he prepares for me everyday my kits with medicine, the things that I have to take and everything [. . .] and he says that it is his responsibility. In fact right now I have the [prescription] of all medicines, because he is going to pick me up to go and buy them. So he is vigilant about what I need: the medicines that are about to run out and everything. He took this as his responsibility. My responsibility is to take the medicines that he prepares and leaves in a package [for me].*

d) Responsibilities Surrounding HIV Transmission

HIV-positive men live with constant fears of transmitting the virus to their partners. Many of these men report that keeping their partners with no virus is something of primary important in their lives. Due to the sad and negative process that they have experienced as HIV-positive men, they would not like to pass the virus to their long time companion. Claudio, a man in his early thirties, recently diagnosed with HIV, indicates that

> *To me the main challenge is to have complete certainty that I am not going to hurt him [. . .] [that] I will never hurt him or transmit [to] him the disease. [The challenge] is the responsibility that the times we have sex, we do it totally sure that we are being safe, that we are not doing anything that implies more risk that the one that normally exists when having sex [. . .] and to be always prepared and to talk to my partner with regard to the psychological situation [. . .] [The challenge] is that we both are ok, knowing myself positive with HIV and he being aware of me having the virus.*

For some men, the fears of infecting their partner are so big that they never ejaculate inside their partners even if they wear condoms.

It should also be mentioned, that for some other men, although they are also concerned with not infecting their partner, they expressed that each member in the couple

has its share of responsibility. In this context, respondents do not feel the obligation of assuming all of it if their partners became infected. They have talked with their partners about wearing condoms and doing whatever possible to avoid transmission. When they have not used condoms for whatever reason, they make clear that the responsibility is mutual. They have taken the same attitude with regard to their own infection, and they do not blame anybody else for their HIV status. For a lot of HIV-positive men, assuming that each one is responsible for his own health, has allowed them to discard feelings of guilt in hypothetical situations involving infecting other men. This attitude has been achieved, in many cases, after a long time of interior conflict produced by their HIV diagnosis. And it has allowed them to resume their sexual lives and to enjoy living in partnership.

e) Partner's Fears

In addition to the preoccupation with not transmitting the virus to anyone, HIV-positive men indicate that they have to face their partners' own fears of infection and, in many cases, the inability of both to express their own emotions with regards to the virus and possibilities of transmission. Ruben, a man in a relationship of seven years and with two years of diagnosis, describes how the HIV has brought problems in the relationship. Their major challenge is that each partner has to cope with a slightly different problem: in one case, the HIV-positive partner has to learn how to care for his health and continue having a good quality of life; on the other hand, the HIV-negative partner has to learn how to protect himself from primary infection. In both cases, they need to learn how to support each other and be vigilant about each other needs in terms of health, nutrition, safe sex practices, and so on.

> *[One challenge is] the fears that my partner can have. He is not a person that can express all his emotions as he would like to [. . .] or he has sometimes the desire to support, to express [. . .] but I think that it is a little bit difficult to accept the circumstances he is living [in]. Part [of the challenge] is to accept [the situation]: one part knowing himself positive with HIV and the other negative with HIV. It is complicated because there are two psychologies: the one who knows himself positive and the one who knows he is not. The one that knows himself negative knows that he does not have problems and sometimes he would like to go back to the*

beginning of the relationship. In my case [HIV-positive] the diagnosis was given within the current relationship, so I also have to accept that I have the problem and that I have to learn to care for myself and after that to care for my partner. This is the major conflict that we can face [. . .][as well as the fact] that there could be a moment in which the partner can get tired of offering his support.

10.4 Conclusions

Results from this chapter show the particular problems that men in HIV-discordant relationships face depending on their own HIV status. Contrasting the perceptions of HIV-negative respondents versus HIV-positive respondents allows us to observe some differences on the effect of discordance in their lives. HIV-negative men express their consent to sexual intercourse while having fears of infection, feeling that their interests and own needs have been put in second place to attend to their partners' health needs, and living in a state of uncertainty due to their partners' constant mood changes (as a side effect of medications). On the other hand, HIV-positive men expressed their fears of losing their partners due to their HIV status, their sexual dissatisfaction due to having sexual practices that reduce risk of infection but that are not totally pleasurable to respondents, and their own struggle to keep themselves going in life knowing their HIV-positive status.

All these results lead to situations of vulnerability for both partners. Through respondents' responses it is possible to discern the lack of institutional recognition of HIV-discordant couples, which has led clinics and hospital to provide assistance only to HIV-positive men, neglecting the needs of HIV-negative men. There is no current official program specifically designed to meet the needs of both partners as a couple. HIV-negative men report not knowing how to offer their support to their partners or how to react before a situation of crisis. Answers to their multiple questions are rarely given by health institutions. By the same token, a lot of official health programs offered to HIV-positive men addressed mostly individual health problems. Although these efforts are very important and help substantially to improve the quality of life of patients, most

programs do not consider their personal problems in relation to their discordant partners, which include: patients' fears of losing their partner due to their HIV status; couples' crises due to the lack of interest in sex in one partner or due to fears of infection in both partners; and crises derived from putting aside personal preferences of types of sex in order to decrease risks of infection. Addressing these issues in a more explicit and integrated way can increase the quality of life of HIV-positive men and their partners.

Chapter 11: Conclusions

The general motivation of this dissertation was to study the meanings that people attach to sex and its effects on sexual behavior in the context of high risk of HIV transmission and re-infection. Drawing on forty-four in-depth interviews with MSM in current or past HIV-discordant couples living in the metropolitan area of Mexico City, the study analyzed whether there is a change in their sexual behavior after mutual awareness of HIV discordance. The basic idea was to identify situations of risks for primary HIV infection or re-infection: whether people continue or even start having sexual practices that include direct contact with their partners' bodily fluids. In these cases, I studied the circumstances around which such events occur and how these are related to people's perceptions of sex and bodily fluids in the context of an affective relationship.

Stressing the study of meanings attached to sex and its relation to risky sexual behavior derives from previous studies that show that people with knowledge about HIV/AIDS and its forms of prevention do not consistently have protected sex. These studies show that relying exclusively on information is not sufficient to successfully stop the spread of any disease, no matter how lethal it is. This fact calls for new approaches that recuperate what is in people's mind during sexual interaction and the different factors that facilitate risky sex. It must be taken into account that decisions with regard to sex are not exclusively the result of cognitive processes in which information is the only element that plays a role or material factors, although these are very important too. People may have access to health institutions and means to avoid infection and may still engage in risky practices. Other elements like meanings that people attach to behaviors or the feelings they have toward certain things also intervene in the final result.

The theoretical premise of the study is that people behave toward things based on the meanings they attach to those things (Blumer, 1969). Following Thomas and Thomas (1928; p. 572) it can be said that if things are perceived as real, "they are real in its consequences." These assumptions consider that people recreate meanings during social

interaction through a process of interpretation of events and things they encounter. The particular identity that an individual develops through life also helps to facilitate the creation and re-creation of meanings. Identity is both an effect and a cause of social interaction (Berger, 1967). For this reason this dissertation investigated the perspective that MSM in HIV-discordant couples have toward their sexual lives, condom use and the idea of relationship. It also inquired about their sexual identity and the degree to which respondents have shared their sexual orientation and discordance to HIV.

The relevance of the dissertation derives from the current challenges that health programs face to promote long term changes in the sexual behavior of the population. Particularly important groups are couples discordant to HIV, as the risk of infection and re-infection is evident in this group: as new HIV therapies are developed to prolong the life of HIV-positive men, the accumulated number of persons at risk of infection and re-infection is increasing too (Kalichman, 1999).

The first objective of the dissertation was to study the impact of HIV discordance in the lives of the couples and whether they implemented protected sex or reinforced it through consistent condom use. In Mexico no studies currently report on male couples aware of their HIV discordance. Most findings basically focus on individuals as opposed to couples, and they study particular populations: men attending STD clinics or not involved in a stable relationship at the time of the interview (Izazola et al., 2000; Ramirez et al., 1994). These studies do not reveal how men would behave in case they were aware of the risk of infection or re-infection.

The present results indicate that most men in HIV-discordant couples report condom use on a frequent basis. To the general question of whether they wear condoms on a frequent basis, the majority of these men gave an affirmative answer. A lot of them already had this practice before knowing about their discordance. Many others incorporated condom use after diagnosis of HIV in one partner. In the case of men who started their relationship aware of their discordance to HIV, respondents indicate that they wore condoms since the beginning of their relationship.

Nevertheless, some men, regardless of the moment in which they became aware of discordance, reported practices of risky sex when responding to more specific

questions about their sexual lives (twenty-six out of forty-four). One group indicated that they engage in anal penetration without condoms as a form of foreplay (thirteen out of forty-four). They indicate that this is just part of the sexual game, and they avoid internal ejaculation, or they withdraw to put a condom on, especially if the partner penetrating is HIV-positive. If the uninfected partner plays an insertive role, internal ejaculation may occur under the assumption that chances of primary or secondary infection are minimal. The identification of these practices is important because there is no warranty that they are risk free. In the population studied, this could potentially lead to sero-conversion in the uninfected partner and to secondary health problems in the HIV-positive partner. This information is difficult to obtain through close-ended questionnaires because they usually ask about "wearing or not wearing condoms during anal sex," but leave no room to go into more detail about sexual practices. Conversely, qualitative interviews show that risk practices are not always detected through close-ended questions because in many instances men assume that by avoiding internal ejaculation they are not exposing themselves to a high risk of infection, even if they have unprotected anal sex as a form of foreplay, and consequently they do not report such practices. Because of these factors, using qualitative methodology allows for a more in-depth understanding of actual sexual practices: the knowledge that even if men wear condoms on a frequent basis they still may engage in other risky practices can provide health professionals with more information to design health campaigns.

A second group of men openly reported direct contact with their partners' bodily fluids through anal or oral sex on a frequent basis. Some incorporated condom use shortly after diagnosis of HIV in one partner, but later on they stopped wearing them. The rest of the men reported wearing condoms half of the time or only in cases that the HIV-positive partner played an insertive role. Although the number of these respondents is relatively small their participation in the study is important because it helps to elucidate different factors of unprotected sex in a population aware of their risks of infection. The qualitative character of the present study does not allow us to omit this latter group of participants because they give answers to fundamental questions about why some people, even

knowing their risk of infection, do not have protected sex. Future quantitative analyses can elucidate the prevalence of these and other risky practices.

The second objective of the dissertation was to study the meanings that respondents give to sex and prevention in the context of their HIV discordance. Once again, the premise here is that depending on the perceptions that people have about these issues, will help determine whether they will protect themselves against HIV infection or re-infection. Results indicate that reasons provided for engaging in foreplay without condoms or to being in direct contact with their partners' bodily fluids are diverse and have to do with respondents' perceptions of pleasure and intimacy in the context of a stable relationship. Results support previous findings in that sex is experienced as an emotionally and "spiritually" meaningful event (Carrillo, 2002). These findings support the thesis that individuals appropriate cultural values, and they connect them with their own experiences (Blummer, 1969; Berger, 1967): in this case men re-create normative values of romance and intimacy, and they connect them with their own sexual history.

The relatively small amount of research with HIV-discordant gay men on this topic, basically in English-speaking countries, indicated that the reasons reported by men for unprotected sex were mutual trust and love, as well as the idea that raw sex is a sign of monogamy and stability (Worth et al., 2002; Remien et al., 1995; Rhodes and Cusick, 1994;). The present dissertation elaborates more on such ideas and contributes to the discussion by showing how a similar concept of commitment to the relationship may lead to different paths of sexual risk depending on their interpretation.

The difference between respondents' exposing themselves to the risk of infection and re-infection derives from the association of unprotected sex to commitment and how raw sex is judged as necessary to reach deep emotional and physical intimacy. For men who reported condom use on a frequent basis, commitment was about mutual responsibility to keep each other's health in good status: the HIV-negative partner needs to remain without the virus to care and provide for his partner, and the HIV-positive partner needs to care about his nutrition and to maintain good levels of CD4s cells and low levels of viral load to reduce possibilities of HIV transmission. All this in turn will positively affect the quality of their relationship. When commitment is understood in this

way, practices of unprotected sex are more likely to be avoided. Consequently in such cases, condom use is observed as a regular practice. It must be said that this perception of protected sex and commitment was developed by respondents through constant interaction with some doctors and other HIV-positive men who gradually learned to detach from initial ideas of "if my partner has the virus I should already have it" or "I don't care if I get infected because we must have same destiny as a couple." In spite of this initial tendency, the existence of such institutional or social networks that help respondents to go from a "mutual abandonment attitude" to a "mutual care attitude" seems not to be accessible to all respondents or not to be provided in a systematic way. From this situation arises the need to create or reinforce health programs for the mutual benefit of members of HIV discordant couples.

When commitment was understood as "mutual abandonment" and the need to share the same destiny, practices of unprotected sex were reported more frequently: unprotected anal penetration and withdrawal without ejaculation, or even direct contact with bodily fluids. In these cases, men mentioned having taken risks due to the "love" they have for their partner and to express their mutual commitment. For many HIV-negative respondents, not wearing condoms is a form of showing support to their partners, a way to tell them they are not afraid of them. In the case of anal foreplay without condoms, HIV-negative respondents indicate that their partners show their commitment by delaying physical pleasure and by avoiding internal ejaculation. In such cases, there is always the question of how much these couples are really avoiding infection or re-infection through such practices, as there is no guarantee that an exchange of bodily fluids will not occur.

Other men, regardless of their HIV status, reported that not wearing a condom does not make a lot of difference in terms of physical pleasure (seventeen out of forty-four). They report, nevertheless, that avoiding condoms increases their idea of deep intimacy and bonding with their partners. For this reason, a lot of these couples have launched into sexual intercourse without protection in spite of the risks. For all these couples, commitment is understood as unconditional support, abandoning themselves to the partner without limitation.

The lack of anal penetration, especially in young men or in couples of recent formation, is perceived as an indicator of a lack of commitment or a sign that the relationship is not on good terms. Consenting to this practice is not only because of the respondents' desire for pleasure, but also because such consent is understood as the respondents' obligation to please their partners. Even if respondents have other practices like mutual masturbation, touching or kissing, they could not imagine their relationships without anal penetration. They consider this practice as an important dimension of sexual life. All of this suggests that health campaigns that promote alternative forms of sexual interaction to anal penetration are limited because of the respondents' current conceptions of sexuality. Although these men respond positively to such messages, and they incorporate practices of low or zero risk of infection, they will also expect to have anal penetration as another practice within their sexual lives, especially in those cases in which such activity is an indicator of how good their relationship is.

In addition, some men also reported that along with anal penetration, direct contact with their partners' bodily fluids is fundamental for the relationship. This practice helps them to reach orgasm, which is understood as the maximum expression of physical pleasure and emotional connection with their partners. These men report that being in contact with their partners" semen, despite the risk to their health that this practice represents, energizes their relationship and makes them feel as if they were receiving something unique from their partners. For this reason, these respondents indicate that wearing condoms reduces the intensity of the desired intimacy they are looking for with their partners.

The third objective of the dissertation was to study the challenges that respondents face living in an HIV-discordant couple. Although here I merely explore the points of view of HIV-negative men versus those of HIV-positive men about their relationships, the results point to the lack of an integral health infrastructure that address the needs of both members of a couple. This lack reflects the social stigma associated with homosexuality that still prevails in many sectors of the Mexican society and among many people who offer health services. Despite the continuing opening of Mexican society to ideas about diversity and the increasing visibility of a gay community in Mexico,

homosexuality is considered by many to be an antisocial behavior contrary to the socially constructed characteristics of masculinity (Stern et al., 2003; Diaz, 1998; Murray, 1995). This attitude translates both into constant episodes reported by respondents in which they were the target of mistreatment or discrimination by health personnel, and also translates into the insufficient (or nonexistent) counseling aimed at the needs of HIV-positive respondents in terms of their relationships or intimate lives. Examples of these needs are: respondents' fears that their partners will end the relationship or couples' crises due to periods of not having sex because of fears of infection in both members. On the other hand, HIV-negative respondents report feeling that their own needs have been placed below those of their partners and that health personnel don't take them into account as needing integral counseling. HIV-negative respondents complain about not finding answers to their fears of infection and their anxieties about not knowing what to do during a partner's health crisis, and so on.

The fourth objective of this dissertation was to explore the sexual identity of respondents and their processes of coming out. The dissertation recuperates the concept of "identity" as part of an individual's subjective reality that results from a dialectic process between that individual's interpretation of reality and social interaction (Berger and Luckmann, 1967). The concept of "identity" is relevant for the present research because it affects the creations and recreation of meanings that respondents have toward sexual practices, protection and same sex relationships. It helps to understand respondents' particular sexual behavior in the context of HIV discordance. In this respect, previous literature indicates that in contexts of extreme homophobia and machismo, MSM tend to deny their sexual preference and to self-identify as heterosexual men. Living in an environment hostile to homosexuality reduces the chances of raising a same-sex preference identity and limits individuals' capacity for linking affection to sex, or to the possibility of having a stable male partner, or to have protected sex. Instead it increases the number of casual encounters and encourages the lack of condom use. The fortuitous situations in which these men have sex, leads them to the idea that bringing a condom when they go to bed with other men would be equal to accepting their homosexual desires (Diaz, 1998; Carrier, 1995).

According to previous research, a family's attitudes toward homosexuality can have negative consequences for an individual's representation of sexuality and the way he or she enacts it. Research indicates that sexual silence about homosexuality can lead men to dissociate family relations from their gay friends, creating two different worlds in their lives (Diaz, 1998; Carrier, 1995). In extreme cases, such separation can also lead to dissociation between affections, sexual desire, and to personal shame, which in turn are associated with the previously mentioned situations of unprotected anonymous sex, sometimes in the context of intoxication with alcohol (Diaz, 1998; Carrier, 1995).

In this respect, respondents' processes of coming out with regard to their sexual orientation show the different degrees of discussion within immediate social networks that exist: there are stories of men who have not talked about their sexuality with their families but where it is known implicitly. The family tolerates the respondent's sexuality but nobody talks openly about it. In this case interaction between the respondent's family and his gay friends may also be limited. But there were also stories of men whose families openly accept respondents' sexuality and interact with their partners in everyday life and with their gay friends; there were even cases whose relatives realized the respondents' sexuality and helped them to get out of the "closet" (before respondents realized their own desire for men). Regardless of their particular situation, all respondents had already gone through a process of self-acceptance by the time of the interview. Interaction with other gay men and attendance to gay social events or places had reinforced their identity as gay or homosexual men. This acceptance was translated into their decision to be in partnership with other men: sometimes for more than twenty years, some other times for less than one year, but even in these cases they reported other experiences with stable partners before. So when respondents talked about their sexual identity, forty out of forty-four reported being gay or homosexual, two reported being bisexual, and only two refused to use a term, as they considered such a thing as a labeling process that leads to discrimination. In all cases respondents were happy with their sexual orientation.

None of the respondents reported a heterosexual identity or showed interest in expressing their masculinity through stereotypical conceptualizations of

macho/machismo: playing exclusively an insertive role or interpreting this as a sign of power or being penetrated as a social stigma. The greater or lesser preference for a particular practice (insertive/receptive) depended on different factors including but not limited to their partners' desire, the length of the relationship, and personal moods, among others. If penetration was an important source of pleasure, it was for both men independently of the role they had during a given encounter. Insertive versus receptive roles during anal penetration were not used by respondents to talk about their sexual identity. In fact, penetration was not always present; penetration was not the only form of sexual interaction between these men. Under these circumstances, a lack of condom use due to internalizations of stereotypes of machismo or homophobia reported by previous literature)seem not to be a factor for these couples. Instead, previously mentioned meanings attached to sexuality based on ideas of romantic love and conceptions of commitment were relevant to explain differences between those who consistently used condoms and those who did not.

My interviews did not show a systematic correspondence of respondents to gender stereotypes (masculine/feminine or insertive/receptive roles). This goes in line with Prieur's hypothesis that identities and sexual practices of middle-class MSM in Mexico may not be strongly tied to gender classifications, unlike her study with lower income transvestites and their partners in a suburb of Mexico City (Prieur, 1998 and 1996).

This investigation represents the point of view of my interviewees, and it is not designed to be generalized to other populations. This study refers to a specific group of MSM. Because the purpose of the study was to show that information and perceptions of risk are not the only elements informing people's decisions, it excludes men that are not aware of their HIV status and have not received scientific information about the disease. A lot of respondents were recruited through clinics, support groups or physicians, so they have already gone through a reflective process about protection, sexuality and illness. This research project shows that in spite of information, many of them still have several practices of risk. In order to know the extent to which the present results apply to broader groups of men or to the general population, future research of s quantitative nature needs

to be done; research that inquires about reasons for having sex, for having or not protection and for specific practices of risk including anal penetration as foreplay is highly needed.

The interviewees are relatively more educated than adult men in Mexico City, and they are also older with a greater concentration in the middle age groups between thirty and thirty-five, as opposed to a concentration in younger age groups. The sample studied here belongs predominantly to a middle class sector (broadly defined). It is a middle class that is not a homogeneous group and which offers constant examples of men that would be at both ends of such a social group. Respondents' family backgrounds are an important factor explaining such differences. A lot of men interviewed have similar levels of education or occupational status; however, economic resources of participants are not necessarily the same. I noticed a difference in economic resources, such as area of residence or type of property, when visiting some participants in their houses or from their own descriptions of how they live. Some interviewees own houses located in upper middle neighborhoods, while others own apartments in lower middle class sectors of the city, and some others may simply rent or live with their families. In this sense, the difference between coming from a consolidated middle class background and from a lower income family was reflected in respondents' socioeconomic background. Despite different economic possibilities and family financial status, I could not draw definite conclusions about this point with regard to differences in respondents' perceptions of sexuality or even personal histories of coming out of the closet. On both ends of the social spectrum, I found men who would not wear condoms as an expression of intimacy and mutual abandonment, as well as men who reported frequent condom use as a way of showing their commitment with their partner. I also interviewed men whose sexual orientation caused a lot of conflict and pain within their families at some point of their lives regardless of social background, as well as men whose disclosure of their sexual orientation was much less problematic without this necessarily being tied to education or occupational status.

Appendices

Appendix A.1: Characteristics of HIV-Negative Men

(It includes HIV- Men Who Currently Have a Discordant Partner,
HIV- Men Who in the Past Had a Discordant Partner and Are Still Negative,
and Men that Were HIV– and Had a Discordant Partner But Now Are Sero-converted)

Interviewee's Pseudonyms (a)	**HIV Status**	**Last Time Being Tested**	**Age**	**Education**	**OCCUPATION**	**Partner's HIV Status**	**Was the Partner Interviewed?**	**Time with that Partner**	**Time couple Knew about Discordance**	**Who Does Respondent Live With?**	**Does He Currently Have a Partner?**
Miguel	HIV + (b) See note	1 year ago	37 years	Undergraduate Degree	Unemployed. Formerly Sales Supervisor	Now dead. Before Positive	No	4 ½ years	4 years	Father	No. Partner is dead.
Pablo	Negative	5 months Ago	22 years	2 Years College	Shop assistant	Positive	Yes	7 months	6 ½ months	Partner	Yes
Jose	Negative	10 months ago	33 years	Undergraduate Degree	Professional at a Bank	Positive	Yes	6 years	5 years & 10 months	Partner	Yes
Pedro	Negative	1 year ago	21 years	Completing High School Diploma	Shop Assistant at Departmental Store	Positive	Yes	8 months	6 months approx	Partner/Friend	Yes
Joaquin	Negative	1 year ago	43 years	Junior High School	Employee in Administrative Services	Positive	No	15 years	3 years	Partner	Yes
Ricardo	Negative	8 months ago	39 years	High School Diploma plus 3 Years Specialized Studies	Artist	Positive (his 2 previous Partners)	No	(d) See note Most recent: 3 ½ years Least recent: 4 years	(d)See note Most recent: 3 ½ years Least recent: 4 years	By himself	No (e) See note
Luis	Negative	1 month ago	42 years	Some High School	Independent Salesman	Positive	Yes	7 years	2 years	Partner, next to Family	Yes
Ramiro	Negative	1 year ago	29 years	College Degree & Further Specialization	Professional in Administrative Services	Positive	Yes	5 months	5 months	Family on weekdays and Partner's on weekends	Yes
Roberto	Negative		26 years	High School Diploma	Fitness Instructor	Positive	No	6 months	6 months	Brother	Yes
Juan	Negative	1 ½ year ago	24 years	Completing Undergraduate	Student	Positive	Yes	6 years	5 years & 11 months	Family	Yes

				Degree							
Mario	HIV+ (c)See Note	5 years ago. Current Cd4=335 VL= 50	42 years	Undergraduate Degree	High School Teacher	Positive	Yes	8 years	8 years. After 2 ½ years informant was diagnosed HIV+	Partner and Partner's female cousin	Yes
Adrian	Negative	1 year ago	53 years	Junior High School	Owns Small Business	Positive	Yes	22 years	2 years	Partner	Yes
Alejandro	Negative	1 year ago	32 years	Undergraduate Degree	Administers Family Business	Positive	Yes	6 months	5 months	Parents	Yes
Valentin	Negative	1 ½ year	38 years	Undergraduate Degree	Director of School	Positive	Yes	15 years	4 years	His partner	Yes
Jesus	Negative	2 months ago	25 years	High School Diploma	Dancer and Fitness Trainer	Positive	Yes	8 months	8 months	His partner	Yes
Diego	Negative	1 month ago	32 years	Master's Degree	Unemployed. Formerly: Manager	Positive	Yes	2 years	1 ½ years	By himself	Yes
Tomas	Negative	6 months	24 years	Master's Degree	Engineer	Positive	Yes	2 years	9 months	Partner	Yes
Felipe	Negative	2 years ago	25 years	Some High School	Student	Positive	Yes	4 years	3 years ½	His partner and Mother in Law (in her house)	Yes
Alfonso	Negative	1 year ago	30 years	Undergraduate Degree	High School Teacher	Positive	Yes	9 years	8 years	His family	No (f) See Note
German	Negative	5 months ago	36 years	Master's Degree	Translator and University Professor	Positive	No	15 years	7 or 9 years	His Partner	Yes
Guillermo	Negative	1 month	44 years	Some High School	Employee in Construction Company	Positive	Yes	5 years	4 years	Partner & Partner's Father & Mother	Yes

Notes:
(a) The names used to identify respondents are pseudonyms. To protect the identity of respondents, I did not use their real names.
(b) Miguel is currently HIV-positive. Nevertheless he was interviewed about the time when he was still HIV-negative and had, sequentially, two HIV-positive partners.
(c) Mario is currently HIV-positive, but he was interviewed about the time when he did not know his HIV status and had an HIV-positive partner.
(d) Ricardo had two HIV-discordant partners in the past: the most recent partner is mentioned first.
(e) Ricardo does not have a partner at the moment. He was interviewed about the time when he had two HIV-positive partners.
(f) Alfonso does not have a partner at the moment. He was interviewed about the time when he had an HIV-positive partner. His discordant partner was also interviewed.

Appendix A.2: Characteristics of HIV-Positive Men.

(It includes HIV+ Men Currently Engaged With a Discordant Partner
or Who Recently Broke Up with such a Partner)

Interviewee's Pseudonyms (a)	**HIV Status**	**Time Since Diagnosis**	**Cd4**	**Viral Load**	**Age**	**Education**	**Occupation**	**Partner's HIV Status**	**Was the Partner Interviewed?**	**Time with that Partner**	**Time Couple Knows of Discordance**	**Who Does Respondent Live With?**	**Does He Currently Have a Partner?**
Rodolfo	Positive	2 ½ years	428	Don't remember	38 years	Undergraduate Degree	Unemployed. Formerly: Human Resources of Hospital	Negative (his current & his previous partners)	No	Most recent: 1year Least recent: 8 years	Most recent: 1 year Least recent: 1 year	Current Partner. Before with Family	Yes
Enrique	Positive	2 years			31 years	Undergraduate Degree	Social Worker in a Food Bank	Negative	No	8 years	2 or 4 years	Parents	Yes
Alberto	Positive	1 year			25 years	Some College	Dance teacher in primary schools	Negative	Yes	7 months	6 ½ months	Partner	Yes
Raymundo	Positive	14 years		Undetectable	48 years	Engineer	Aromatherapy & Massage	Negative	Yes	6 years	5 years & 10 months	Partner	Yes
Sergio	Positive	16 years	264	3500	36 years	Some High School	4 Years as Office Boy & Retired from IMSS due to HIV	Negative	Yes	8 months	6 months approx	Partner /Friend	Yes
Gabriel	Positive	2 years	176	50	34 years	Undergraduate Degree	Professional for Private Company	Negative	No (only in pilot interviews)	8 years	2 years	Family weekdays/ Partner weekends	Yes
Raul	Positive	14 years	780	Undetectable	48 years	Incomplete Bachelor	Employee Public Institution	Don't know (hasn't been tested)	No	8 years	8 years	Partner	Yes
Ruben	Positive	2 years	378	Less than 50	38years	Some College	Salesman	Negative	Yes	7 years	2 years	Partner next to Partner's Family	Yes
Sebastian	Positive	7 months	178	Don't Know	33 years	Undergraduate Degree	Professional for Private Company	Negative	Yes	5 months	5months	By himself	Yes
Martin	Positive	10 years	350	20, 000	48 years	Graduate Studies	University Professor	Negative	No	4 years	4 years	By himself	No (broke up recently)

Oscar	Positive	6 years	1400	Less 50	41 years	Undergraduate Degree	Professional for Private Company	Negative	Yes	6 years	5 years & 11 months	Family	Yes
Hector	Positive	More than 8 years	1000	Undetectable	33 years	Undergraduate Degree	Employee in Public Institution	Positive Before he was Negative	Yes	8 years	8 years. After 2 ½ years his partner was diagnosed HIV+	His partner and female cousin	Yes
Jaime	Positive	2 years	More 385	Less than 163	42 years	Undergraduate Degree	Owns Small Business	Negative	Yes	22 years	2 years	His partner	Yes
Ismael	Positive	5 months	308	1800	35 years	Undergraduate Degree	Artist	Negative	No	14 years	5 months	Partner	Yes
Claudio	Positive	5 months	Don't know	Don't know	33 years	Master's Degree	Doctor	Negative	Yes	6 months	5 months	By himself	Yes
Jorge	Positive	12 years	537	Less than 400	41 years	Some High School & Technical Education	Language Teacher	Negative	Yes	8 months	8 months	Partner	Yes
Gustavo	Positive	18 years	675	Undetectable	39 years	Undergraduate Degree	Professional for Private Company and Owner of Small Business	Negative	Yes	2 years	1 ½ years	By himself	Yes
Manuel	Positive	4 years	368	Undetectable	38 years	Some College	Primary Teacher	Negative	Yes	15 years	4 years	Partner	Yes
Eduardo	Positive	6 years	297	14000	46 years	Undergraduate Degree	Unemployed. Formerly: Independent Professional	Negative	Yes	4 years	3 ½ years	Partner and mother	Yes
Marcos	Positive	10 years	282	Undetectable	33 years	High School Diploma	Staff for NGO	Negative (2 discordant partners)	Yes (b) See Note	9 years	8 years	Family	Yes
Gregorio	Positive	4 years	810	Undetectable	28 years	High School Diploma	Shop Assistant	Negative	Yes	2 years & 4 months	9 moths	Partner	Yes
Gerardo	Positive	5 years	740	Undetectable	33 years	Undergraduate Degree	Professional	Negative	Yes	5 years	4 years	Partner and his own mother &father	Yes
Ignacio	Positive	10-12 years	320	Undetectable	40 years	Some High School	Unemployed/Freelance Technician	Negative	No	5 years	4 years 11 months	Mother and brother and sister in law	Yes

(a) The names used to identify respondents are pseudonyms. To protect the identity of respondents, I did not use their real names.
(b) Marcos already broke up with his first HIV-negative partner. He has now a second HIV-negative partner. Only his first discordant partner was interviewed. The second one did not want to be interviewed.

Appendix B: Cover Letter

Invitación a Participar en el Estudio

Estimado participante,

Mi nombre es Benjamín Nieto Andrade y como parte de mi tesis de doctorado me gustaría entrevistar por separado a ambos miembros de parejas discordantes a VIH (parejas donde un miembro es VIH positivo y otro miembro es VIH negativo o no sabe su serostatus a VIH), o a personas que formaron parte de parejas que se sabían discordantes a VIH.

El objetivo es explorar diversos aspectos sobre sexualidad, emociones y prevención de VIH. Para lograr esta meta, me gustaría hacerte preguntas sobre prácticas e identidades sexuales, la importancia de la actividad sexual en la pareja y el uso del condón.

Los resultados de la entrevista servirán para escribir mi tesis de doctorado y también podrían mejorar campañas sobre VIH/SIDA y programas de salud para atender a hombres que viven con VIH/SIDA y a sus parejas masculinas.

La información que por separado tú y tu pareja provean en esta entrevista será manejada en forma estrictamente confidencial. Nada de lo que digas será compartido con nadie que no esté asociado a este estudio, así que puedes sentirte en confianza para hablar de lo que quieras sin ningún problema.

Si hay alguna pregunta de la entrevista que no desees contestar o en algún momento dado prefieres detener la entrevista, sólo tienes que decirlo.

A continuación se presenta un pequeño documento que especifica en mayor detalle los objetivos del estudio y las características de la entrevista. Si tienes alguna duda al leerlo, con todo gusto la aclararemos.

Muchísimas gracias,

Benjamín Nieto-Andrade
Estudiante de Doctorado en Sociología
Universidad de Texas en Austin
Correo Electrónico: benjamín@prc.utexas.edu
Tel. en México: 8596-0354

IRB# 2003-11-0083

Appendix C: Informed Consent Letter

Consentimiento Informado para Participar en un Estudio de Investigación

La Universidad de Texas en Austin

Estimado participante.

Esta forma contiene información sobre un estudio en el que se requiere tu participación. El investigador principal (Benjamín Nieto-Andrade) o su representante (ayudante) te describirá el estudio y contestará todas tus preguntas. Por favor lee la información que se presenta abajo y pregunta sobre cualquier cosa que no entiendas antes de decidir si participas en el estudio. Tu participación es enteramente voluntaria y tu puedes decidir no participar sin perder ningún beneficio al que puedas tener derecho.

Título del Estudio:

Emociones y Conductas de Riesgo: Un Estudio de Caso de Hombres que Viven con VIH y sus Parejas Masculinas en México.[4]

Investigator Principal:

Benjamín Nieto-Andrade (Investigador Principal)
Estudiante de Doctorado en Sociología
Universidad de Texas en Austin (UT-Austin)
Teléfono en Austin: 001- 512 - 475-8643

Debra Umberson, Ph. D. (Directora de Tesis)
Directora del Departamento de Sociología
Universidad de Texas en Austin
Teléfono en Austin 001- 512 - 471-3255

Organización Financiadora:

Fundación Andrew W. Mellon para estudiantes de doctorado del Centro de Estudios en Población (Universidad de Texas en Austin).

[4] El título de la versión final de la tesis doctoral cambió ligeramente. Sin embargo el contenido es el mismo que se propone en el proyecto.

¿Cuál es el propósito de este estudio?

En este estudio se entrevistará a 30 parejas masculinas discordantes a VIH (parejas donde un miembro es VIH positivo y otro miembro es VIH negativo o no sabe su serostatus). El estudio incluye tanto a parejas discordantes que actualmente tienen lazos afectivos y sexuales, como a personas que en el pasado formaron parte de parejas que se sabían discordantes a VIH. El objetivo es explorar diferentes aspectos sobre intimidad y emociones, prácticas e identidades sexuales, prevención de VIH, importancia de relaciones sexuales en la vida cotidiana, y procesos de aceptación homosexual.

¿En qué consiste tu participación en este estudio?

Tú y tu pareja serán entrevistados por separado sobre cuestiones de intimidad y emociones, practicas e identidades sexuales, prevención de VIH, importancia de las relaciones sexuales en la vida diaria y procesos de aceptación homosexual. Tu información será tratada confidencialmente: nada de lo que tú digas será informado a otra persona (incluyendo a tu pareja). La guía de entrevista para tí y tú pareja están ya preparadas, de manera que ninguna información que tú des será utilizada para formular preguntas a tu pareja.

¿Cuáles son los posibles riesgos o incomodidades de este estudio?

Muchas preguntas pueden parecer un poco delicadas debido a que este estudio explora cuestiones sobre sexualidad, relaciones íntimas con tu pareja y prevención de VIH. La entrevista incluye preguntas sobre aspectos íntimos de tu vida sexual con tu pareja y/u otras personas con quien hayas tenidos relaciones sexuales. Si en algún momento de la entrevista tu no deseas contestar una pregunta o deseas detener la entrevista tu puedes hacer eso sin ningún problema.

La información será utilizada para mi tesis de doctorado en la Universidad de Texas en Austin. El fin de la entrevista no es proveer consejería sobre VIH a los participantes. Sin embargo, a continuación hay una serie de organizaciones a las que puedes acudir si tu deseas recibir consejería sobre VIH. Estas organizaciones trabajan en forma independiente a este estudio y no tienen conexión alguna con la Universidad de Texas en Austin.

Algunas instituciones a las que puedes acudir si deseas consejería sobre VIH:

Programa de VIH/SIDA del DF
Benajmín Hill No.24
Col. Condesa

06170, México, D.F.
Tel./Fax: 5515-8311

Clínica Especializada Condesa
Benjamín Hill No.24
Col. Condesa
06170, México, D.F.
Tel./Fax: 5271-6439

HOT LINES

Centro de información de educación sexual
5627-7090 y 01(800)317-0500

Planificatel
01(800)010-3500

Diversitel
Línea de la diversidad sexual
5272-25-22
diversitel@hotmail.com

Ayuda en caso de violencia sexual
PGJDF
5575-5461

SEP
Denuncia de abusos sexuales en escuelas públicas
5328-1060
operdgee@sep.gob.mx

De joven a joven
5658-1111

Línea lésbico, gay y bisexual de la Cd. de México
5272-0778
Lunes a viernes de 15:00 a 22:00 hrs.
Sábados de 12:00 a 20:00 hrs.

SAPTEL
5395-0660

S.O.S. GAY
Línea de asistencia legal
5611-7452
Lunes a viernes 9:00 a 14:00 y de 16:00 a 21:00 hrs.
5629-9800 clave 204316 a nombre de abogados consultores

¿Cuáles son los posibles beneficios de este estudio para tí o para otras personas?

La información que tú y tu pareja provean a este estudio es muy importante para detectar necesidades y problemas que enfrentan hombres que viven con VIH y sus parejas masculinas (seronegativas o que no saben su serostatus). Con esa información se pueden desarrollar programas de salud para reducir niveles de ansiedad en algún miembro de la pareja, reducir practicas sexuales de riesgo, y atender posibles problemas que hayan surgido en la pareja a raíz de la presencia del VIH.

Si decides tomar parte en este estudio ¿tendrá algún costo para ti?
No, no tendrá ningún costo para ti. Tu participación simplemente consiste en ser entrevistado aproximadamente 2 horas en un lugar que garantice la confidencialidad y privacidad de tu información.

¿Recibirás compensación económica por este estudio?

No, desafortunadamente no hay compensación económica para los participantes de este estudio. Este estudio no es de carácter lucrativo y sólo tiene propósitos académicos. Tu valiosa participación es voluntaria (y confidencial).

¿Existe algún riesgo físico asociado a este estudio?

Este estudio no supone ningún riesgo físico. Sólo consiste en entrevistas por separado a hombres con VIH y a sus parejas masculinas sero-negativas a VIH (o que desconocen su serostatus a VIH), asegurando la confidencialidad y privacidad de su información. También incluye a personas que en el pasado formaron parte de parejas que se sabían discordantes a VIH. En todos los casos, se busca entrevistar a parejas discordantes a VIH donde cada miembro sabe o sabía al momento de la relación el serostatus de su compañero o pareja.

Si tu no deseas participar en este estudio ¿qué otras opciones tienes?

Tu participación en este estudio es totalmente voluntaria. No participar en este estudio no afectará en lo absoluto la relación actual que pudieras tener o tu relación futura con alguna organización de VIH/SIDA o de cualquier otro tipo.

¿Cómo puedes dejar de formar parte de este estudio y a quien debes llamar si tienes alguna duda respecto al estudio?

Si tu no deseas continuar en este estudio puedes contactar al investigador principal (Benjamín Nieto-Andrade) al teléfono 85-96-03-54 en la Ciudad de México o al 001-512-4758643 en Austin (Texas). Tú tienes total libertad para decidir interrumpir tu

participación en este estudio en cualquier momento, sin perder algún beneficio al que actualmente tengas derecho. A lo largo del estudio se te notificará de cualquier cambio que sea hecho respecto a la investigación y que pueda afectar tu decisión de participar.

Si tienes alguna pregunta sobre tus derechos como participante en este estudio, también puedes contactar a Clarke A. Burnham, Ph.D., Director del Comité Institucional para la Protección de las Personas (IRB por su siglas en inglés) de la Universidad de Texas en Austin. El teléfono del Dr. Clarke A. Burnham en Texas, Austin es: 001-512- 232-4383.

¿En qué forma se garantiza la confidencialidad y privacidad de tu información?

Después de grabar en cassette la entrevista (con previo consentimiento de tu parte), ésta será transcrita y los cassettes serán destruidos. En los cassettes no habrá ningún nombre o etiqueta que pudiera permitir la identificación de los entrevistados. Ninguna persona ajena a este estudio tendrá acceso a la información de las entrevistas. **Únicamente personal autorizado del Comité Institucional para la Protección de las Personas (IRB en la Universidad de Texas) y de la Fundación Adrew W. Mellon tienen derecho a revisar las entrevistas transcritas, protegiendo la confidencialidad de dicha información según lo marca la ley. De otra manera las entrevistas transcritas no serán mostradas a nadie sin tu consentimiento, al menos que ello sea requerido por la ley o una decisión de la corte.**

Si los resultados de este estudio son publicados o presentados en conferencias científicas, tu nombre o identidad no serán revelados.

Si tu lo permites, a) la entrevista que durará aproximadamente 2 horas será grabada en cassettes, b) los cassettes tendrán etiquetas que no permitirán la identificación de ninguno de los participantes; c) los cassettes serán guardados en un lugar seguro (archiveros con seguro); los cassettes serán escuchados únicamente por el investigador principal y su ayudante para los propósitos de este estudio; e) los cassettes serán destruidos después de ser transcritos.

¿Hay algún beneficio que el investigador de este estudio obtenga de tu participación?

La información que tú y tu pareja provean sólo será utilizada para fines académicos: escribir una tesis de doctorado y, potencialmente, hacer recomendaciones a programas de prevención y consejería sobre VIH en México.

Firmas:

Como representante de este estudio, he explicado el propósito, los procedimientos, los beneficios, y los posibles riesgos relacionados a esta investigación:

Firma y nombre de la persona que obtiene el consentimiento Fecha

Tú has sido informado sobre los propósitos del estudio, los procedimientos, los posibles beneficios y riesgos, y también has recibido una copia de esta forma. También has tenido la oportunidad de hacer preguntas antes de firmar, y se te ha informado de que puedes hacer preguntas en cualquier otro momento. Tú has decidido voluntariamente participar en el estudio. Firmar esta forma, no significa declinar a tus derechos legales.

Nombre del Participante o seudónimo Fecha

Firma del Participante Fecha

Firma del Investigador (Benjamín Nieto-Andrade) Fecha

Appendix D: In-depth Interview Guide

Guía de Entrevista para Hombres con VIH y para sus Parejas Sero-negativas

Nota: Esta guía de entrevista se hará por separado a cada miembro de parejas discordantes a VIH. Aunque las preguntas parecen dirigirse exclusivamente a hombres sero-positivos a VIH, su formulación cambiará cuando se entreviste a miembros sero-negativos de la pareja (para indicar que el informante es VIH negativo). Por la dinámica propia de cada entrevista, no todas las preguntas se formularán "verbatim", ni se pretende agotar todas ellas. Esta es sólo una guía que facilitará cubrir los principales temas de la investigación.

SECCION 1: INFORMACION SOCIO-DEMOGRAFICA

1 Características del informante

-¿Qué edad tiene usted?
-¿Cuál fue el último año escolar cursado?
-¿En qué ciudad nació?
-¿Cuál es su ocupación actual? ¿Y en años anteriores?
-¿Con quién vive ahora?
-¿Conoce usted su serostatus a VIH?¿Cuándo fue la última vez que se hizo la prueba de Elisa?
-Si el informante es HIV positivo:¿Cuál es su conteo de CD4? ¿Cuál es su carga viral? ¿Toma usted antiretrovirales? ¿Desde cuándo?
-¿Conoce usted el serostatus de su pareja? ¿Cuál es?
-¿Su pareja conoce el serostatus a VIH de usted?

2 Características de la pareja

-¿Edad de su pareja actual?
-¿Cuál fue el último año escolar cursado por su pareja?
-¿Cuál es la ocupación actual de su pareja? ¿Y en años anteriores?

SECCION 2: EFECTO DEL VIH EN LA VIDA SEXUAL DE LA PAREJA

1. Entiendo que usted es VIH positivo y su pareja actual es VIH negativo. ¿Podría por favor decirme, con el mayor detalle posible, si la presencia de VIH ha cambiado las prácticas sexuales con su actual pareja? ¿En qué ha consistido tal cambio?

-tipo de prácticas sexuales
-frecuencia de actividad sexual
-uso del condón o alguna otra medida preventiva

2. ¿A qué atribuye usted tal cambio en las prácticas sexuales con su pareja (efecto fíisico del VIH-SIDA, miedo a infección, deseo de proteger a la pareja, otras)?

3. Si hubo cambios ¿siente usted que el cambio en sus prácticas sexuales debido al VIH fue para mejorar o para hacer más difícil su vida sexual?

4. ¿Considera usted importante tener relaciones sexuales con su pareja regularmente? ¿Por qué?

-jerarquizar principales razones pare tener relaciones con su pareja actual
-defincón de relaciones sexuales
-principales prácticas sexuales que tienen (sexo anal, oral, masturbación mutua)
-importancia de penetración anal para una vida sexual plena

5. ¿Cómo calificaría la vida sexual que actualmente tiene con su pareja (satisfactoria, insatisfactoria, ¿por qué?)? ¿Está usted insatisfecho con algún aspecto de su vida sexual? ¿Hasta qué punto usted tiene relaciones sexuales en la forma en que desea? [5]

6. ¿Después de saber que usted es VIH positivo y su pareja actual es VIH negativo, ha habido algún intento o forma de prevenir la trasmisión de VIH en la pareja? ¿Qué lo ha motivado (miedo a infectar a la pareja, afecto/cariño por la pareja, otros motivos)?

-Tipo de prevención: condón, evitar sexo anal u oral, otro
-¿De quién ha sido la iniciativa?
-¿Cómo ha funcionado: en qué situaciones ha funcionado, en qué situaciones no ha funcionado?

SECCION 3: EMOCIONES Y USO DEL CONDON

1. Me gustaría preguntarle sobre la última vez que usted tuvo relaciones sexuales con su pareja actual sin usar condón (o cuando el condón se rompió o se salió). ¿Podría tratar de recordar tanto como sea posible esa ocasión y decirme cómo sucedió? (Trate de recordar qué pasó, qué estaba haciendo y como se sentía en el momento? [6]

-¿Cómo sucedió? (¿Cúando? ¿Dónde? ¿Quién inició el juego sexual?)

---

[5] Esta pregunta fue recuperada de World Health Organization (2003) Quality of Life-HIV. Bajado del internet en August 2003: www.popcouncil.org/horizons/AIDSquest/instruments/WHOQOL-HIV.doc

[6] Esta pregunta general y los puntos específicos que se desprenden de ella fueron tomados del California State Office of AIDS and CDC. Bajado del Internet en Noviembre del 2002: www.caps.ucsf.edu/capsweb/projects/accessurvey.html

-¿Cuál fue o cuáles fueron las razones para tener relaciones sexuales en ese momento (placer sexual, afecto a la pareja, no pudo reusarse...)?
-¿Qué sucedió? (anal sex, oral sex, masturbación mutua, otro)
-Si no usaron condón ¿qué determinó no haberlo utilizado?
-Si el condón se salió o se rompió ¿cómo cree qué sucedió? ¿en qué momento se dio cuenta? ¿qué hizo al darse cuenta?
-¿Hubo alguna diferencia en esta última experiencia sexual sin condón respecto a situaciones en que sí usó condón (placer sexual, emociones)? ¿Y respecto a otras ocasiones en que NO usó condón?

2. ¿Cree usted que los condones funcionan para prevenir la transmisión de VIH-SIDA? ¿Qué le gusta y qué le disgusta de los condones? Cuando escucha la palabra condón ¿qué es lo primero en que usted piensa (con qué lo asocia)?

3. ¿Cree usted que los condones reducen o no reducen la posibilidad de intimidad emocional (o no importa)? ¿Y qué hay sobre el placer físico?

4. ¿Han platicado sobre la posibilidad de transmisión del VIH o de reinfección en su pareja? ¿Cuál ha sido su reacción y la de su pareja? ¿Cómo cree que reaccionaría usted SI su pareja adquiriera el VIH por tener relaciones sexuales con usted (o si usted adquiriera el virus –en caso de que el informante sea VIH negativo)? ¿Qué hay sobre reinfección de quien es portador de VIH?

-miedo
-no le importaría ¿por qué?
-cualquier otra reacción

5. SOLO PARA VIH positivo ¿Cómo cree usted que adquirió VIH? ¿Podría recordar cuando pudo haber sucedido, con quién estaba, qué relaciones sexuales practicó, y si utilizó condón o algún tipo de prevención?

6. ¿Cuáles son los principales retos de vivir en una pareja discordante a VIH?
-problemas de la pareja
-necesidades de alguien que vive con alguien que es discordante a VIH
-qué es lo particular

SECCION 4: INICIO DE LA VIDA SEXUAL Y ATRACCION POR OTROS HOMBRES

1. ¿Cómo se da usted cuenta sobre su atracción por otros hombres?

2. ¿Cómo vivió usted su preferencia sexual durante su infancia, su adolescencia y su vida adulta? ¿Con quién socializaba? ¿Se sentía discriminado?

3. ¿Cómo inició su vida sexual?

4. ¿Cómo "salió del closet"? ¿Cómo empezó a relacionarse con otros hombres sexualmente: a conocer amigos, novios...?

5. ¿En qué ambientes y/o personas sí comparte su preferencia sexual y en cuáles no?

6. ¿En qué ambientes se siente discriminado actualmente por su preferencia sexual? ¿Me puedes explicar cómo ha pasado?

7. ¿Se siente discriminado actualmente por ser portador de VIH (o su pareja)? ¿Le importa que la gente sepa que usted o su pareja es portador a VIH? ¿Cuál cree que sería la reacción de la gente si le hablara de su serostatus a VIH (o el de su pareja)?

8. ¿Su familia sabe que usted tiene relaciones sexuales con otros hombres?¿Podría platicarme cómo fue el proceso de "salir del closet" con su familia? ¿Cuál es la relación que actualmente lleva con ellos? ¿Conversa abiertamente con ellos sobre su vida sexual o sobre los amigos homosexuales que usted tiene (conocen a su pareja, qué relación tienen sus familiares con su pareja)?

9. ¿Su familia sabe que usted (o su pareja) tiene VIH? ¿Cómo se enteraron? ¿Podría decirme cuál ha sido la reacción de su familia? ¿Cree usted que lo apoyan como usted desea? ¿Platica usted asuntos sobre el VIH/SIDA con su familia?

SECCION 5: ASOCIACION ENTRE IDENTIDADES SEXUALES Y PRACTICAS SEXUALES

1. ¿Hay algún término que usted utilice para definir su identidad sexual (homosexual, gay, bisexual, heterosexual, otro)? ¿Qué significa para usted ese término (cómo lo explicaría)?

2. ¿Hay alguna práctica sexual que prefiera más que otras (cuál es)? ¿qué prácticas sexuales a usted de plano no le gustan o no realiza? (Nota: ver si utiliza los términos activo, pasivo, internacional para definir sus prácticas sexuales)

3. ¿Con su pareja actual alguna vez ha tenido alguna práctica sexual que usted realmente no deseaba? ¿Qué práctica? ¿Por qué (mostrar confianza, tenía miedo, dinero, otra)? ¿Podría describirme la situación? ¿Cómo se sentía usted?

4. ¿Cómo se distribuyen usted y su pareja las tareas domésticas u otras responsabilidades? ¿Quién cubre los mayores gastos económicos: renta, agua, luz, teléfono, comida, transporte? ¿Recibe usted alguna clase de ayuda económica de su pareja?

5. ¿Ha habido alguna situación difícil por la que hayan pasado como pareja: quién ha tomado las decisiones?

SECCION 6: REACCIONES DE LOS INFORMANTES SOBRE LA ENTERVISTA[7]

1. ¿Hay alguna pregunta que yo no hice y que usted considera importante que yo debí haber preguntado?

2. ¿Hay alguna pregunta que para usted fue difícil responder?

3. ¿Hay algún tema sobre sexualidad o relacionado con VIH/SIDA que no discutimos y que usted considera importante compartir conmigo?

4. ¿Aceptaría usted una futura entrevista si este proyecto requiriera más información?

7 Esta sección fue tomada de Gonzalez-Lopez (2000) Beyond the Bed Sheets, Beyond the Borders: Mexican Immigrant Women and their Sex Lives Tesis Doctoral, the University of Southern California, Los Angeles.

Bibliography

Allen, Susan et al. (2003) "Sexual Behavior of HIV Discordant Couples After HIV Counseling and Testing" AIDS Vol. 17, pp. 733-740.

Almaguer, Tomas (1996) "Hombres Chicanos: una Cartografia de la Identidad y del Comportamiento Homosexual" in Debate Feminista, año 6, Vol..11, Abril, Mexico, pp. 44-77.

Amuchastegui, Ana (2001) Virginidad e Iniciacion Sexual. Experiencias y Significados Mexico, D.F.: EDAMEX/Population Council.

Andersen, John et al. (1999) "Condom Use and HIV Risk Behaviors Among U. S. Adults: Data From a National Survey" Family Planning Perspectives Vol. 31, January, p. 24-28.

Babbie, Earl R. (2001) The practice of social research. California: Thomson/Wadsworth.

Bankole, Akinrinola et al. (1999) "Determinants of Trends in Condom Use in the Unites States, 1988-1995" Family Planning Perspectives Vol. 31, No. 6, p. 264-271.

Beckerman, Nancy L. (2002) "Couples Coping with Discordant HIV Status" AIDS Patient Care and STDs Vol. 16, No. 2, pp. 55-59.

Beckerman, Nancy L. et al. (2000) "Key Emotional Issues for Couples of Mixed HIV Status" Social Work in Health Care Vol. 31, No. 4, pp. 25-41.

Berger, Peter L. and Thomas Luckmann (1967) The Social Construction of Reality. A Treatise in the Sociology of Knowledge New York: Anchor Books Edition.

Bhat Mari, P. N. (1990) "Estimating transition probabilities of age misstatement" *Demography* Vol. 27, No. 1 (Feb 1990): pp149 (15).

Blechner, Mark J. (2002) "Intimacy, Pleasure, Risk and Safety: Discussion of Cheuvront's 'High Risk Sexual Behavior in the Treatment of HIV-Negative Patients'" Journal of Gay and Lesbian Psychotherapy Vol. 6, No. 3, pp. 27-33.

Blumer, Herbert (1969) Symbolic Interactionism Berkely: University Of California Press.

Bock, Philip K. (1988) Rethinking Psychological Anthropology. Continuity and Change in the Study of Human Action New York: W. H. Freeman and Company.

Boulton, M. et al. (1995) "Gay Men's Accounts of Unsafe Sex" AIDS Care Vol. 7, No. 5, pp. 619-630.

Bova, Carol and Aanda Durante (2003) "Sexual Functioning Among HIV-Infected Women" AIDS Patient Care and STDs Vol. 17, No. 2, pp. 75-83.

Bronfman, Mario and Nelson Minello (1995) "Habitos sexuales de los migrantes temporales mexicanos a los Estdos Unidos. Practicas de riesgo para la infeccion por VIH" en Mario Bronfman et al. SIDA en Mexico. Migracion, adolescencia y genero Mexico: CONASIDA.

Buchacz, Kate et al. (2001) "Socio-demographic, Behavioral and Clinical Correlates of Inconsistent Condom Use in HIV Sero-discordant Heterosexual Couples" Journal of Acquired Immune Deficiency Syndrome Vol. 28, Num 3, pp.289-297.

California State Office of AIDS and CDC. Retrieved November 2002 from: (http://www.caps.ucsf.edu/capsweb/projects/accessurvey.html)

Cantu, Lionel (2002) "A Place Called Home: A Queer Political Economy: Mexican Immigrant Men's Family Experiences" in Christine L. Williams and Arlene Stein (eds.) Sexuality and Gender, Massachusetts: Blackwell Publishers Ltd., pp. 382-394.

Carballo-Dieguez, Alex et al. (1999) "Reliability of Sexual Behavior Self-Reports in Male Couples of Discordant HIV Status" The Journal of Sex Research Vol. 36, Issue 2, p. 152

Carrier, Joseph (1995) De Los Otros. Intimacy and Homosexuality Among Mexican Men, New York: Columbia University Press.

Carrillo, Hector (2002) The Night is Young; Sexuality in Mexico in the Time of AIDS Chicago: The University of Chicago Press.

Carrillo, Hector (1999) "Cultural Change, Hybridity and Male Homosexuality in Mexico" en Culture, Health and Sexuality, Vol. 1, No. 3, 223-238.

Catania, Joseph A. et al (1992) "Prevalence of AIDS-Related Risk Factors and Condom Use in the Unites States" Science Vol. 258, No. 5085, p. 1101-1106.

CENSIDA (2006) Casos de SIDA y Personas Viviendo con VIH. Cifras al 30 de Septiembre del 2006 Mexico, D.F. Retrieved Nov. 15, 2006 (http://www.salud.gob.mx/conasida/estadis/2006/sidapvvih30sep.pdf)

CENSIDA (2005) El SIDA en Cifras. Mexico, D.F. Retrieved Nov. 15, 2006 (http://www.salud.gob.mx/conasida)

Chodorow, Nancy J. (1999) The Power of Feelings. Personal Meaning in Psychoanalysis, Gender and Culture New Haven, Connecticut: Yale University Press, US.

Choi, Kyung-Hee et al. (2002) "Unprotected Sex and Associated Factors Among Young Asian and Pacific Islander Men Who Have Sex with Men" AIDS Education and Prevention, Vol. 16, Num 6., pp. 472-481.

Civic, Diane "The Association between Characteristics of Dating Relationships and Condom Use Among Heterosexual Young Adults" AIDS Education and Prevention Vol. 11, No. 4, pp. 343-352.

Connell, R. W. (1995) Masculinities, Berkeley: University of California Press.

Connell, R. W. and G. W. Dowsett (1993) Rethinking Sex. Social Theory and Sexuality Research Philadelphia: Temple University Press.

Cooper, Lynne M and Cheryl M. Shapiro (1998) "Motivations for Sex and Risky Sexual Behavior Among Adolescents and Young Adults: A Functional Perspective" Journal of Personality and Social Psychology Vol. 75, No. 6, pp. 1528-1558.

Cordova-Plaza, Rosio (2003) "Mayates, Chichifos y Chacales: Trabajo Ssexual Masculino en la Ciudad de Xalapa, Veracruz" in Marinella Miano Borruso Caminos Inciertos de las Masculinidades (comp.), Mexico, D.F.: INAH, pp.141-161.

Craib, Ian (1995) "Some Comments on the Sociology of Emotions", Sociology, Vol. 29, No. 1 p.15(8).

Cruz-Sierra, Salvador (2001) "La Pareja Gay Masculina en Mexico: algunos Indicadores" in Cuicuilco. Revista de la Escuela Nacional de Antropologia e Historia Nueva Epoca, Vol. 8, No. 23, September- December, Meixco: ENAH, pp. 113-125.

Daker-White, Gavin and Jenny Donovan (2002) "Sexual Satisfaction, Quality of Life and the Transaction of Intimacy in Hospital Patients' Accounts of Their (Heter)sexual Relationships" Sociology of Health and Illness Vol. 24, No. 1, pp.89-113

Davis, Mark (2002) "HIV Prevention Rationalities and Sero-status in the Risk Narratives of Gay Men" Sexualities, Vol. 15, No. 3, pp. 281-299.

D'Emilio, John and Estelle B. Freeman (1999) "Intimacy between Men" in Robert A. Nye (Ed.) Sexuality Oxford: Oxford University Press.

Diaz, Rafael (1998) Latino Gay Men and HIV. Culture, Sexuality and Risk Behavior New York: Routledge.

Doring, M. Teresa (1990) El Mexicano ante la Sexualidad Mexico, D. F.: Ediciones y Distribuciones Hispanicas.

El-Bassel, Nabila et al. (2000) "Fear and Violence: Raising the HIV Stake" AIDS Education and Prevention Vol. 12, No. 2, pp. 154-170.

Ewbank, Douglas C. (1981) Age misreporting & age-selective under enumeration: sources patterns & consequences for demographic analysis. National Academy Press 1981, Washington DC.

Falck, R. S. et al (1997) "Factors Influencing Condom Use Among Heterosexual Users of Injection Drug and Crack Cocaine" AIDS Weekly Plus May, p. 42

Farmer, Paul (1999) Infections and Inequalities. The Modern Plagues University of California Press, Berkeley.

Famer, Paul (1997) "Ethnography, Social Analysis, and the Prevention of Sexually Transmitted HIV Infection Among Poor Women in Haiti" in Marcia Inhorn and Peter Brown (Eds.) The Anthropology of Infectious Diseases New York: Gordon and Breach.

Faulkner, Sandra L. and Phyllis Kernoff Mansfield (2002) "Reconciling Messages: The Process of Sexual Talk for Latinas" Qualitative Health Research Vol. 12, No. 3, pp. 310-328.

Fisher, Gene A. (1989) "Durkheim and the Social Construction of Emotions" Social Psychology Quarterly Vol. 52, No.1, pp. 1-9.

Flores, Elena et al. (1998) "Socio-cultural Beliefs Related to Sex Among Mexican American Adolescents" Hispanic Journal of Behavioral Sciences Vol. 20, No. 1, pp. 60-83.

Foreman, Faith E. (2003) "Intimate Risk, Sexual Behavior Among African American College Women" Journal of Black Studies Vol. 33, No. 5, pp. 637-653.

Galligan, Roslyn F. and Deborah J. Terry (1993) "Romantic Ideals, Fear of Negative Implications, and the Practice of Safe Sex" Journal of Applied Social Psychology Vol. 23, No. 20, pp. 1865-1711.

Gabe, Ann (1996) "Sociology's emotion" The Canadian Review of Sociology and Anthropology Vol. 34, n. 4 p385 (15).

Garcia, Brigida and Orlandina De Oliveira (1994) Trabajo Femenino y Vida Familiar en Mexico Mexico, D.F.: El Colegio de Mexico.

Geringer WM et al. (1993) "Knowledge, attitudes and behavior related to condom use and STDs in a high risk population" *The Journal of Sex Research*; Vol. 30: pp. 75-83.

Gold, Ron S. et al. (1994) "Unprotected Anal Intercourse in HIV-infected and Non-HIV-Infected Gay Men" The Journal of Sex Research Vol. 31, No. 1, pp. 59-77.

Gonzalez-Block, Miguel A. and Ana Luisa Liguori (1992) El SIDA en los Estratos Socioeconomicos de Mexico Cuernavaca, Mexico: Instituto Nacional de Salud Publica.

Gonzalez-Lopez, Gloria (2005) Erotic Journeys. Mexican Immigrants and their Sex Lives Los Angeles, CA: University of California Press.

Gonzalez-Lopez, Gloria (2000) Beyond the Bed Sheets, Beyond the Borders: Mexican Immigrant Women and their Sex Lives PhD diss., University of Southern California, Los Angeles.

Gonzalez-Lopez, Gloria and Gutmann, Matthew C. (2005) "Machismo" in Maryanne Cline Horowitz (editor) New Dictionary of the History of Ideas, Vol. 4 (Machiavellism to Phrenology), New York: Thompson and Gale, pp. 1328-1329.

Gonzalez-Perez, Cesar Octavio (2003) "Intimidad y Ciudadania. Experiencias Desde la No Heterosexualidad" in Marinella Miano Borruso Caminos Inciertos de las Masculinidades (comp.), Mexico, D.F.: INAH, pp. 27-47.

Gonzalez-Perez, Cesar Octavio (2003) Travestidos ald desnudo: homosexualidad, identidades y luchas territoriales en Colima Mexico, D.F.: CIESAS.

Guiddens, Anthony (1992) The Transformation of Intimacy. Sexuality, Love and Eroticism in Modern Societies Cambridge, Polity Press.

Gutmann, Matthew C. (1996) The Meanings of Macho. Being a Man in Mexico City Los Angeles, CA.: University of California Press.

Hernandez, M. et al. (1992) "Sexual Behavior and Status for Human Immunodeficiency Virus Type 1 Among Homosexual and Bisexual Males in Mexico City" American Journal of Epidemiology April 15, Vol. 135, No. 8, pp.883-894.

Hernandez-Giron, Carlos et al. (1999) "Factors Associated with Condom Use in the Male Population of Mexico City" International Journal of STD and AIDS Vol. 10, pp. 112-117.

Herold, Joan M. et al. (1992) "Premarital Sexual Activity and Contraceptive Use in Santiago, Chile" Studies in Family Planning, Vol. 23, No. 2, May-April, pp. 128-136.

Higginbotham, S. et al. (2000) "Adoption of Protective Behaviors Among Persons With Recent HIV Infection and Diagnosis" in The Body: An AIDS and HIV Information Resource Retrieved June 16, 2006 (www.thebody.com/cdc/behaviors.html).

Hillier, Lynne et al. (1999) "Neverending Love and Blowing your Load: The Meanings of Sex to Rural Youth" Sexualities Vol. 2, No. 1, pp. 69-88

Hirsch, Jennifer et al. (2002) "The Social Constructions of Sexuality: Marital Infidelity and Sexually Transmitted Disease-HIV Risk in Mexican Migrant Community" American Journal of Public Health, Vol. 92 (8), pp. 1227-1237.

Hirsh, Jennifer (2003) A Courtship After Marriage. Sexuality and Love in Mexican Transnational Families Los Angeles, CA: University of California Press.

Hirsh, Jennifer and Constance Nathanson (2001) "Some Traditional Methods are More Modern than Others: Rhythm, Withdrawal and the Changing Meanings of Gender and Sexual Intimacy in the Mexican Companionate Marriage" Culture, Health and Sexuality Vol. 3, No. 4, p. 413-428

Hochschild, Arlie Russell (1998) "The Sociology of Emotions as a Way of Seeing" in Gillian Bendelow and Simon J. Williams (Eds.) Emotions in Social Life. Critical Themes and Contemporary Issues London: Routledge.

Hoff, Colleen C. et al. (1997) "Differences in Sexual Behavior Among HIV Discordant and Concordant Gay Men in Primary Relationships" Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology Vol. 14, pp. 72-78.

INEGI, (2005) Conteo de Poblacion y Vivienda. Aguascalientes, Aguascalientes.http://www.inegi.gob.mx/

INEGI (2001), Estados Unidos Mexicanos. XII Censo General de Poblacion y Vivienda, 2000. Tabulados Basicos y por Entidad Federativa. Bases de Datos y Tabulados de la Muestra Censal Aguascalientes, Ags., Mexico: INEGI.

Izazola-Licea, Jose Antionio et al. (2003) "Sexual Behavior Patterns and HIV Risks in Bisexual Men Compared to Exclusively Heterosexual and Homosexual Men" in Salud Publica de Mexico Vol. 45, Supp. 5, S622-S671.

Izazola-Licea, Jose Antonio et al. (2000) "Prevalence of Same Gender Sexual Behavior and HIV in a Probability Household Survey in Mexican Men" in The Journal of Sex Research, Feb., Vol. 37, No. 1, p. 37

Izazola-Licea, Jose Antionio et al. (1995) "Transmisión Homosexual del VIH/SIDA en Mexico" in Salud Publica de Mexico, Nov-Dec, 37, No. 6, pp. 604-614.

Izazola-Licea JA and Kathlyn Tolbert K (1993) Comportamiento sexual en la Ciudad de México. Encuesta 1992-1993 Secretaría de Salud-CONASIDA, Mexico, D.F., Mexico.

James, Veronica and Jonathan Gabe (Eds.) (1996) Health and the Sociology of Emotions, Oxford: Blackwell Publishers/Editorial Board.

Kalichman, Seth C. et al. (2002) "HIV Transmission Risk Behaviors among HIV-Positive Persons in Serodiscordant Relationships" International Journal of STD and AIDS Vol. 13, pp. 677-682.

Kalichman, Seth C. (1999) "Psychological and Social Correlates of High-Risk Sexual Behaviour Among Men and Women Living with HIV/AIDS" AIDS Care (August 1), Vol. 11, Issue 4, pp. 415-428.

Kalichman, Seth C. et al. (1997) "Sexual Relationships, Sexual Behavior, and HIV Infection: HIV- Seropositive Gay and Bisexual Men Seeking Prevention Services" Professional Psychology, Research and Practice, August, Vol. 28, No. 4, pp. 355-361.

Kemper, Theodore D. (1978) A Social Interactional Theory of Emotions New York: John Wiley and Sons.

Ku, Leighton et al. (1994) "The Dynamics of Young Men's Condom Use During and Across Relationships" Family Planning Perspectives Vol. 26, Issue 6, Nov-Dec, pp. 246-251

Laumann, Edward O. and John H. Gagnon (1995) "A Sociological Perspective on Sexual Action" in Richard G. Parker and John G. Gagnon (eds.) Conceiving Sexuality. Approaches of Sex Research in Post Modern World New York: Routledge

Laumann, Edward O., John H. Gagnon, Robert T. Michael, and Stuart Michaels (1994) The Social Organization of Sexuality. Sexual Practices in the United States Chicago: The University of Chicago Press.

Laumann, Edward O., John H. Gagnon, Robert T. Michael, and Stuart Michaels. National Health and Social Life Survey, 1992: [United States] [Computing File]. ICPSR version. Chicago, IL: University of Chicago and National Opinion Research Center [producer], 1995. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 1995.

Lutz, Catherine A. (1988) Unnatural Emotions. Everyday Sentiments on a Micronesian Atoll. Their Challenge to Western Theory, Chicago: The University of Chicago Press.

Meltzer, Bernard et al. (1975) Symbolic Interactionism. Genesis, Varieties and Criticism Boston, Mass.: Routledge and Kegan Paul.

Michael, Robert T. et al (1994), Sex in America. A Definitive Survey Boston, Mass.: Little Brown and Company.

Moatti, Jean-Paul et al. (1991) "Determinants of Condom Use among French Heterosexuals with Multiple Partners", American Journal of Public Health Vol. 18, No. 1, January, pp. 106-109.

Moreau-Gruet, Florence et al. (2001) "Management of the Risk of HIV Infection in Male Homosexual Couples" AIDS, Vol. 15, pp. 1025-1035.

Murray, Stephen O. (1995) Latin American Male Homosexualities Albuquerque: University of New Mexico Press.

McQuiston, Chris and Ann Gordon (2000) "The Timing is Never Right: Mexican Views of Condom Use" Health Care for Women International, Vol. 21, Issue 4, p. 277-291.

Nencel, Lorraine (1996) "Pacharacas, Putas and Chicas de su Casa: Labelling, Femininity, and Men's Sexual Selves in Lima, Peru", in Melhuus and Stolen (eds.) Machos, Mistresses, Madonnas: Contesting the Power of Latina American Gender Imagery New York: Verso, pp. 56-83.

Nuñez-Noriega, Guillermo (2001) "Reconociendo los Placeres, Desconstruyendo las Identidades. Antropologia, patriarcado y homoerotismos en Mexico" in Desacatos. Revista de Antropologia Social, No. 6, primavera-verano, Mexico, D.F.: CIESAS, pp. 15-34.

Nuñez-Noriega, Guillermo (1999) Sexo Entre Varones. Poder y Resistencia en el Campo Sexual Mexico, D.F.: Miguel Angel Porrua/El Colegio de Sonora/PUEG.

O'Leary, Ann (2000) "Women at Risk for HIV From a Primary Partner: Balancing Risk and Intimacy" Annual Review of Sex Research Vol 11, pp 191-235

Palmer, Robert and Robert Bor (2001) "The Challenges to Intimacy and Sexual Relationships for Gay Men in HIV Serodiscordant relationships: A Pilot Study" The Journal of Marital and Family Therapy (Oct) Vol. 27, Issue 4, pp 419-431.

Parish, K.L. et al. (2001) "Safer Sex Decision-Making Among Men With Haemophilia and HIV and their Female partners" Haemophilia Vol. 7, pp. 72-81.

Parker, Richard (1999) Beneath the Equator. Cultures of Desire, Male Homosexuality and Emerging Gay Communities in Brazil New York: Routlege.

Parker, Richard and John H. Gagnon (1995) Conceiving Sexuality. Approaches to Sex Research In a Postmodern World New York: Routledge.

Pedace, Roberto and Nancy Bates (2000) "Using administrative records to assess earnings reporting error in the survey of income and program participation", Journal of Economic and Social Measurement (Fall-Winter 2000): p173 (20).

Perez-Castro, Juan Carlos (2001) "Los Reneke o Nawiki. Un acercamiento a la Homosexualidad Masculina entre los Indígenas Raramuri de la Sierra Tarahumara de Chihuahua, Mexico" in Cuicuilco. Revista de la Escuela Nacional de Antropologia e Historia Nueva Epoca, Vol. 8, no. 23, September- December, Mexico, D.F.: ENAH, pp. 127-141.

Pilkington, Constance J. and Whitney Kern (1994) "Is Safer Sex Necessary with a 'Safe' Partner? Condom Use and Romantic Feelings" Journal of Sex Research Vol. 31, Issue 3, p.203(8p.)

Pinel, A. "Personal Dynamics of Women Who Risk unprotected Sex With HIV-Infected Partners" (1996) International Conference on AIDS 1996, July 7-12, Abstract No. Mo.D.1684

Prieur, Annick (1998) Mema's House, Mexico City: on Transvestites, Queens, and Machos Chicago: The University of Chicago Press.

Prieur, Annick (1996) "Domination and Desire: Male Homosexuality and the Construction of Masculinity in Mexico" in Melhuus and Stolen (eds.) Machos, Mistresses, Madonnas: Contesting the Power of Latina American Gender Imagery New York: Verso, pp. 83-107.

Ramirez, J. et al. (1994) "AIDS Knowledge and Sexual Behavior among Mexican Gay and Bisexual Men" AIDS Education and Prevention, Apr, Vol. 6, No. 2, pp. 163-74.

Rangan, Sheila and Mukund Uplekar (1999) "Socio-cultural Dimensions in Tuberculosis Control". In Porter JDH and Grange JM (ed.) Tuberculosis. An Interdisciplinary Perspective London: Imperial College Press.

Remien, RH et al. (1995) "Intimacy and Sexual Risk Behavior in Sero-discordant Male Couples" AIDS Care Vol. 7, No. 4, pp. 429-438.

Reyes, Alfonso (1956) Obras Completas Vol II, Mexico, D.F.: FCE.

Rhodes, Tim and Linda Cusick (2000) "Love and Intimacy in Relationship Risk Management: HIV Positive People and Their Sexual Partners", Sociology of Health and Illness, Vol. 22, No. 1, pp. 1-26.

Ritzer, George and Douglas J. Goodman (1996) Modern Sociological Theory New York: Mc-Graw Hill.

Rodriguez, Gabriela and Benno de Keijzer (2002) La Noche Se Hizo Para los Hombres. Sexualidad en los Procesos de Cortejo entre Jovenes Campesinos y Campesinas Mexico, D.F.: Population Council.

Rosaldo, Michelle Z. (1987) "Toward an Anthropology of Self and Feeling" in Culture Theory (eds. Richard Shweder and Robert Levine), Cambridge: Cambridge University Press.

Rosenthal, D. et al. (1998), "Safe Sex or Save Love: Competing Discourses" in AIDS CARES Vol. 10, No. 1. pp, 35-47

Roth, David L. et al. (2001) "Sexual Practices of HIV Discordant and Concordant Couples in Rwanda: Effects of a Testing and Counseling Program for Men" International Journal of STD and AIDS Vol. 12, 181-188.

Saavedra, Jorge (1998) "Economia y Sida en America Latina" en Jose Antonio Izazola (Ed.) El Sida en America Latina y El Caribe: Una Vision Multidisciplinaria, Mexico, D.F.: FUNSALUD/SIDALAC/ONUSIDA.

Sandstrom, Kent L. (1996) "Redefining Sex and Intimacy: The Sexual Self-Images, Outlooks, and Relationships of Gay Men Living with HIV/AIDS" Symbolic Interaction Vol. 19, No. 3, pp. 241-262.

Santelly, John S. et al. (1966) "Stage of Behavior Change for Condom Use: The Influence of Partner Type, Relationship and Pregnancy Factors" Family Planning Perspectives Vol. 28, Issue 3, May-June, pp. 101-107.

Scheff, Thomas J. (1990) Microsociology. Discourse, Emotion and Social Structure Chicago: The University of Chicago Press.

Semple, Shirley J., Thomas L. Patterson and Igor Grant (2002) "Gender Differences in the Sexual Risk Practices of HIV+ Heterosexual Men and Women" AIDS and Behavior, Vol. 16, No. 1, March, pp. 45-54.

Silva, R. C. (1998) "Emotional Involvement, Love, and Commitment: Psychological and Cultural Obstacles for HIV/AIDS Prevention Among Young" International Conference on AIDS 1998 12:240 (Abstract No. 14289).

Skurnick, JH et al. (1998) "Behavioral and Demographic Risk Factors for Transmission of Human Immunodeficiency Virus Type 1 in Heterosexual Couples: Report from Heterosexual HIV Transmission Study" Clinical Infectious Diseases Vol. 25, pp. 855-64.

Skurnick, JH et al. (1998) "Maintenance of Safe Sex Behavior by HIV-Serodiscordant Heterosexual Couples" AIDS Education and Prevention (Dec) Vol. 10, No. 6, pp. 493-505.

Sly, David F. et al (1997) "The Association Between Substance Use, Condom Use and Sexual Risk Among Low Income Women" Family Planning Perspectives Vol. 29, May-June, pp. 132-135.

Sobo, Elisa J. (1995) "Finance, Romance, Social Support, and Condom Use among Impoverished Inner-City Women", Human Organization Vol. 54, No. 2, pp. 115-128.

Sobo, Elisa J. (1995) Choosing Unsafe Sex. AIDS Risk Denial Among Disadvantaged Women, Philadelphia, University of Pennsylvania Press.

Stern, Claudio et al. (2003) "Masculinidad y Salud Sexual y Reproductiva: Un Estudio de Caso con Adolescentes de la Ciudad de Mexico" en Salud Publica de Mexico Vol. 45, Suplemento 1, pp. S34-S43.

Tanfer, Koray et al. (1993) "Condom Use Among US Men, 1991" Family Planning Perspectives Vol. 25, Issue 2, March-April), pp. 61-66.

Thomas, William I. and D.S. Thomas (1928) The Child in America New York: Alfred A. Nopf.

UNAIDS (1998) Looking Deeper into the HIV Epidemic. A questionnaire for Tracing Sexual Networks Geneva: UNAIDS.

Valdespino-Gomez, JL et al. (1995) "Las Enfermedades de Transmision Sexual y la Epidemia de VIH/SIDA" in Salud Publica de Mexico, Nov-Dec., Vol. 37, No. 6, pp. 549-555.

Van Der Straten A. et al. (2000) "Sexual Risk Behaviors Among Heterosexual HIV Sero-discordant Couples in the Era of Post-Exposure Prevention and Viral Suppressive Therapy"AIDS,Vol. 14, No. 4, pp. F47-F54.

Van Der Straten, A. et al. (1998) "Managing HIV among Sero-discordant Heterosexual Couples: Sero-status, Stigma and Sex" AIDS Care (Oct), Vol. 10, Issue 5, pp. 533-548.

Van Devanter, N. et al. (1999) "Heterosexual Couples Confronting the Challenges of HIV Infection" AIDS Care Vol. 11, Issue 2, pp. 181-194.

Wallace, Ruth A. and Alison Wolf (1999) Contemporary Sociology Theory. Expanding the Classical Tradition New Jersey: Prentice Hall.

Weaver, David A. (2000) "The Accuracy of Survey-reported Marital Status: Evidence from Survey Records Matched to Social Security Records", Demography 37 (August 2000): p395.

Weijar-Schultz, W.C.M. and H.B.M. Van de Wiel (2003) "Sexuality, Intimacy, and Gynecological Cancer" Journal of Sex and Marital Therapy Vol. 29(s), pp.121-128.

Whitehead, Paul C. and David Carpenter (1999) "Explaining Unsafe Sexual Behavior: Cultural Definitions and Health in the Military" Culture, Health and Sexuality Vol. 1, No. 4, pp. 303-315.

Whittington, LH William et al. (2002) "Sexually Transmitted Diseases and Human Immune-Deficiency Virus-Discordant Partnerships Among Men who Have Sex with Men" Clinical Infectious Diseases (Oct), Vol. 35, Issue 8, pp. 1010-1018.

Williams, S. J. and G. Bendelow (1998) "Introduction: Emotions in Social Life: Mapping the Sociological Terrain" in Gillian Bendelow and Simon J. Williams (eds.) Emotions in Social Life. Critical Themes and Contemporary Issues London: Routledge.

World Health Organization (2003) Quality of Life-HIV. Retrieved August 2003 from: www.popcouncil.org/horizons/AIDSquest/instruments/WHOQOL-HIV.doc

Worth, Heather et al. (2002) "Somewhere Over the Rainbow: Love, Trust and Monogamy in Gay Relationships" Journal of Sociology Vol. 38, No. 3, pp.237-253.

Vita

Benjamin Nieto-Andrade was born in Mexico City, on September 28, 1968, the son of Lorenzo Nieto and Raquel Andrade. He received his degree of Bachelor of Arts in February, 1994 from the Universidad Nacional Autonoma de Mexico (UNAM). From 1990 to 1994 he worked as research assistant at El Colegio de Mexico. In 1995 he entered the Facultad Latinoamericana de Ciencias Sociales (FLACSO), from which he obtained the degree of Master of Arts in Population Studies in August, 1997. From 1998 to 1999 he worked as researcher for the Instituto Nacional de Salud Publica, Cuernava, Mexico, and as consultant and assistant for various organizations: the United Nations Development for Women (UNIFEM), the Panamerican Health Organization (PAHO), and Grupo Interdisciplinario sobre Mujer, Trabajo y Pobreza (GIMTRAP). During his graduate studies at The University of Texas at Austin he also attended the Rollins School of Public Health at Emory University were he was a fellow in the AIDS International Training and Research Program during summer 2000 and fall 2001 (AITRP).

Publications:

Nieto-Andrade, Benjamin and J. A. Izazola (1999), "Uso del Condon con Parejas No-Estables," Revista de Salud Publica de Mexico No. 43, Marzo-Abril.

Permanent address: Oriente 259 # 279, A. Oriental, Mexico, D.F., 08500

This dissertation was typed by the author.